The News Magazine for Hospitals

HOSPITAL TOPICS

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Read and Pass Along to

- ☐ Medical Director
- ☐ Surgical Supervisor
- ☐ O.B. Supervisor
- ☐ Buyer
- ☐ Supt. of Nurses
- ☐ Medical Librarian
- ☐ Resident Physician
- ☐ Med'l Technologist
- ☐ Chief Engineer
- ☐ Return to the Administrator

WILLIAM EARNGEY
Administrator
Harris Hospital
Fort Worth, Texas

VOLUME XXX—2

FEBRUARY, 1952

ENCOURAGES
SELF-SERVICE

REDUCES
DEMANDS
ON NURSE

the Nightingale

the NIGHTINGALE puts within the patient's reach practically everything he needs for comfortable convalescence. There's wonderful storage space for personal articles . . . "make-up" tray and mirror . . . bookrest . . . electrical outlets for radio or razor . . . convenient adjustable lamp. Out of sight, but close at hand, are bedpan, urinal, emesis basin, wash basin and soap dish. The patient serves himself, enjoys his independence, frees the nurse for more important duties.

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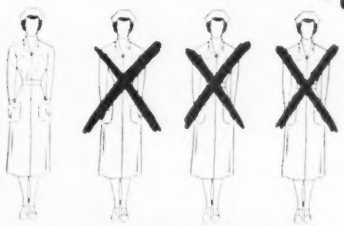
THE *New* HAUSTED WAY

One Nurse Does the Job of Many!



THE HAUSTED "EASY LIFT" WHEEL STRETCHER

The Hausted Wheel Stretcher is the most revolutionary new development in stretchers ever offered. NOW, FOR THE FIRST TIME, HOSPITALS CAN PURCHASE ONE UNIT TO DO ALL THE JOBS OF PATIENT TRANSPORTATION NEEDED. The Hausted "Easy Lift" requires only one nurse to care for even the heaviest patient. And, what's more, with this unit no physical exertion is required of hospital personnel - the stretcher does all the work. By turning one control the patient is transferred from stretcher to bed, quickly, easily, and safely. The unit is available in Silver-Lustre finish. The Hausted stretcher easily adjusts to the height of any Hospital Bed. Stretcher width is 26 inches and length is 72 inches. THE HAUSTED "EASY LIFT" STRETCHER IS IDEAL FOR POST-ANESTHESIA AND RECOVERY ROOM.

THE "EASY-LIFT" NOW HAS TRENDELENBURG POWER-LIFT

A new and important addition to the labor-saving Hausted "Easy-Lift" stretcher is the Power-Lift mechanism that enables a nurse to raise the stretcher to trendelenburg position by simply turning the new Power-Lift Crank.

Special full length side rails and shoulder stops make stretchers adaptable for recovery and emergency use.

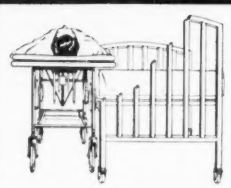
INTRAVENOUS ATTACHMENT

No longer need we see the presently familiar sight of a nurse walking beside a stretcher holding a bottle of fluid in the air. The Hausted attachment eliminates the need for an extra nurse.

THE FOWLER POSITION

By adding the Fowler attachment the Stretcher can be put into proper position in a matter of seconds. This stretcher meets every requirement in transferring patients.

THE TOP FITS OVER THE BED

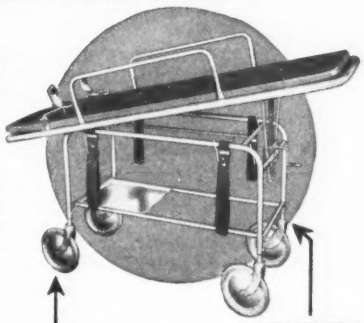


This is the feature that distinguishes Hausted Wheel Stretchers. The stretcher top fits 3¾ inches over the edge of the bed for easier, quicker, and safer patient transfers. The Hausted Standard Stretcher enables just two nurses to transfer even the heaviest patient without fear of disturbing or harming the patient and without strain to the attendants.

THE HAUSTED LOW COST STANDARD WHEEL STRETCHER

This new, low-cost STANDARD STRETCHER provides hospitals with the answer to easier patient transfers. Its sturdy construction and its versatility are the results of careful engineering and research into hospital needs.

The Standard Stretcher's over-the-bed feature is outstanding among its many advantages. Special side rails are available for post-operative or spinal anesthesia use.



AVAILABLE IN 4 CASTER COMBINATIONS

THE HEIGHT ADJUSTS FROM 31 TO 38 IN.

GET THE HAUSTED FACTS NOW!

Contact your Hospital Supply Dealer or write to us direct for descriptive literature and prices.

OTHER VALUABLE FEATURES - -

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- ADJUSTABLE AND REMOVABLE SHOULDER STOPS
- FOWLER ATTACHMENT
- INTRAVENOUS ATTACHMENT
- RESTRAINING STRAPS
- TRENDELENBURG POWER LIFT

HAUSTED WHEEL STRETCHER

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MANUFACTURING COMPANY
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Here it is—the aqueous, repository penicillin which requires no refrigeration.

Label potency is now retained for a full year at room temperature.

You can store it on the shelves—releasing valuable refrigerator space.

And your doctors can carry it with them, always available for instant use.

FLO-CILLIN AQUEOUS *contains 300,000 units of procaine penicillin G in stable, aqueous suspension—free-flowing, of uniform consistency, no diluent to add.*

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SYRACUSE, NEW YORK

News Letter

◄ The President's Health Commission has formally met and organized. Before the next meeting, Feb. 12-13, Chairman Paul B. Magnuson expects to fill the vacancy resulting from Dr. Gunnar Gundersen's refusal to serve on the Commission. The new member will be a physician familiar with AMA policies, but not an official representative of the Association.

◄ In the meantime members of Congress received a letter from Dr. Elmer L. Henderson, chairman, coordinating committee, AMA National Education Campaign, attacking the "unjustified, wasteful and improper use of National Defense funds". Enclosed in the letter was a reprint of President John W. Cline's statement of criticism published in the Journal.

◄ Dr. Howard A. Rusk told those attending the recent Annual Congress on Industrial Health in Pittsburgh, that lack of trained personnel is one of the most serious obstacles to development of health services in plants. None of the nation's schools of public health are filled to capacity, he pointed out, and about one-half of the enrollment is foreign. There are some 2000 physicians in industry now. This number should be doubled by 1953 to keep pace with production, he said. He added that the present total of 13,000 nurses in industry should be increased nearly 50 percent during the same period.

◄ First issue of the official monthly journal of the U.S. Public Health Service, "Public Health Reports" has appeared. It will focus primarily on public health practice, health service administration and on research in these fields. Free subscriptions are available to hospitals and other organizations in the health field.

◄ The Sterilizer Industry Advisory Committee met with the National Production Authority to review metal supply problems. The problem is serious, with 330 hospitals scheduled to open in the next 18 months; approximately 2,000 replacements needed; autoclaves for physicians' and dentists' offices and military requirements to be satisfied. Appreciable savings of scarce nickel and copper are being made through substitution of monel metal for nickel-clad steel and alloy castings for copper castings. Current demand for sterilizers from military and civilian sources is running from 50 to 160 percent above base year which ended July, 1950.

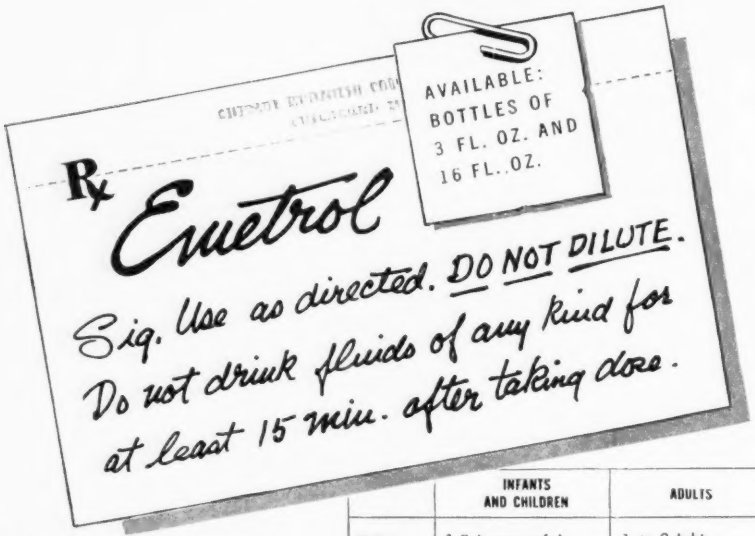
Gordon H. Marshall

FOR RAPID...SAFE...PHYSIOLOGIC CONTROL OF FUNCTIONAL VOMITING

EMETROL®

PHOSPHORATED CARBOHYDRATE SOLUTION

- *before and after anesthesia*
- *in early pregnancy*
- *in epidemic vomiting*


AVAILABLE:
BOTTLES OF
3 FL. OZ. AND
16 FL. OZ.
℞ Emetrol
Sig. Use as directed. DO NOT DILUTE.
Do not drink fluids of any kind for
at least 15 min. after taking dose.

EMETROL is a phosphorated carbohydrate solution which controls functional vomiting through a unique physiologic action. Clinical findings have established its broad therapeutic effectiveness.[1]

Since EMETROL is free of antihistamines, barbiturates, narcotics, or stimulants, it may be prescribed for patients of all age groups with complete safety. Its delicious "peppermint candy" taste makes every dose welcome to the patient.

	INFANTS AND CHILDREN	ADULTS
Before and after anesthesia	1-3 teaspoonfuls 15-30 minutes before anesthesia and as soon as feasible after operation	1 or 2 tablespoonfuls at same intervals as for children
Early pregnancy		1 or 2 tablespoonfuls on arising, repeated every three hours or whenever nausea threatens
Epidemic vomiting	1 or 2 teaspoonfuls at 15-minute intervals until vomiting ceases	1 or 2 tablespoonfuls at 15-minute intervals until vomiting ceases

1. Bradley, J. E., et al.: J. Pediat. 38: 41 (Jan.) 1951

LITERATURE AND SAMPLES TO PHYSICIANS ON REQUEST

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HOSPITAL TOPICS *With The Buyer's Guide*

THE NEWS MAGAZINE FOR THE HOSPITAL STAFF

Personality of the Month

William Earngey

Administrator, Harris Hospital
Fort Worth, Texas

AN outstanding college record was only the beginning of an outstanding career for William Earngey, Administrator, Harris Hospital.

When he graduated from Duke University in 1938, Mr. Earngey was president of the senior class, president of the Sigma Chi Fraternity, and recipient of the Robert E. Lee award for athletics and scholarship, the Alumni award for service to the University, and the Sigma Chi award for the North and South Carolinas Province.

After a post graduate course in Hospital Administration at Duke Hospital, including time with the Duke Endowment Field Service, he became Superintendent of Cherokee County Hospital, Gaffney, South Carolina. He stayed there a year and a half.

Mr. Earngey was Superintendent of Norfolk (Virginia) General Hospital from 1941 to 1951, with the exception of two years in the Navy.

While in Norfolk he continued to occupy positions of responsibility as Chairman, Norfolk City-County Chapter of the National Foundation for Infantile Paralysis, President, Norfolk Hospital Association, President, Virginia Hospital Association, Vice-President, American Hospital Association, and member of the American Hospital Association's Council on Government Relations, Committees on Surplus Foods, and Committee on Veterans Relations. He is also a member of the American College of Hospital Administrators.

Coming to Harris Hospital with such an enviable background, Mr. Earngey is certain to add many new achievements to the Texas hospital, and to his own career.

He married Susan Thomas of Little Rock, Arkansas whom he met while they were both at college. They have two children, William P. Earngey III, nine, and Lynn, eleven. A self acclaimed "professional fish story teller," Mr. Earngey does the fishing to back up his stories, and also enjoys playing golf.

FEBRUARY, 1952

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J. F. Fleming, M.D., *Medical Editor*
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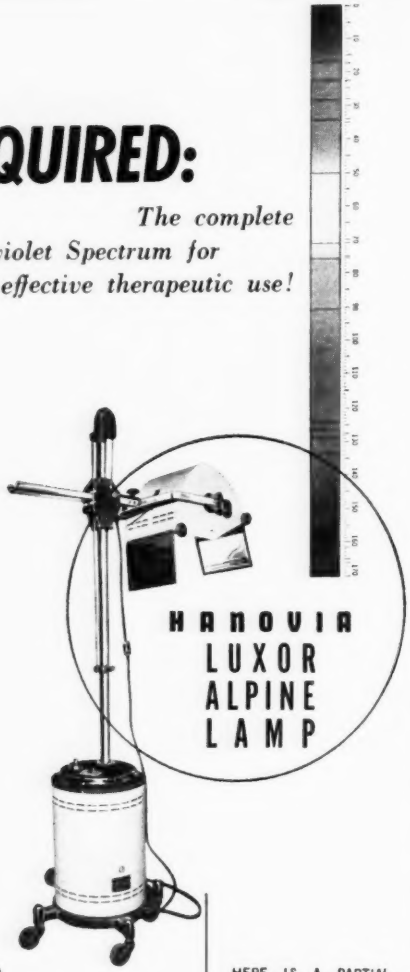
REQUIRED:

The complete Ultraviolet Spectrum for effective therapeutic use!



The complete spectrum with high intensity emission in short, medium and long wavelengths is a definite requirement in the modern practice of light therapy. Because the Hanovia lamp is powered with the highly developed mercury-quartz burner it warrants prime consideration.

HERE IS A PARTIAL LISTING OF DISEASES IN THE TREATMENT OF WHICH ULTRAVIOLET RADIATIONS HAVE PROVED OF IMPORTANT VALUE.

SKIN DISEASES . . . lupus vulgaris, acne vulgaris, eczema, psoriasis, pityriasis rosea, indolent ulcers.

SURGERY . . . sluggish wounds.

CARE OF INFANTS & CHILDREN . . . rickets, infantile tetany or spasmophilia, osteomalacia.

PREGNANT & NURSING MOTHERS . . . preventive measure for rickets.

TUBERCULOSIS . . . of the bones, articulations, peritoneum intestine, larynx and lymph nodes, sinuses.

Also . . . erysipelas—as an adjuvant in the treatment in secondary anemia.

FOR FURTHER DETAILS ADDRESS DEPT. HT - 2-52

HANOVIA

Chemical & Mfg. Co., Newark 5, N. J.

Prescription Pad

By James F. Fleming, M.D.

Tromexan Accepted by A.M.A. Council

The Council on Pharmacy and Chemistry of the A.M.A. has accepted the new oral anticoagulant, Tromexan ethyl acetate, issued by Geigy Pharmaceuticals.

Tromexan has been reported favorably by the Committee on Anticoagulants of the American Heart Assn., by the Medical Research Council of Great Britain, and by numerous independent investigators. In comparison with previously available oral anticoagulant therapy, Tromexan medication possesses the advantages of more rapid absorption, action, detoxification and excretion, as well as reduced cumulative effect. These characteristics significantly reduce the dangers of hemorrhage through accidental overdosage and simplify the management of oral anticoagulant therapy.

Tromexan is recognized for use in conditions characterized or complicated by intravascular clotting, notably coronary thrombosis, thrombophlebitis, pulmonary embolism, auricular fibrillation with embolization, and selected cases of congestive heart failure. It is also used in certain cases following operation or delivery as a prophylactic against thrombosis or embolism. The product is available as scored tablets of 300 mg. and 150 mg.

Surgical Instrument Oil Now Available

Dar-Kol Surgical Instrument Oil is designed especially for lubricating all types of intricate surgical precision instruments, equipment—"electrical or mechanical"—and laboratory equipment that requires accuracy in operation.

Dar-Kol Surgical Instrument Oil will break up rust, corrosion and oil gums. Cleans and lubricates parts thoroughly. It is especially recommended for loosening corroded and gummed joints in surgical instruments.

New Enteric Bacteriostat Introduced

Thaloctin Suspension is a new enteric bacteriostat introduced by Abbott. Each 5 cc. contains phthalylsulfacetimide, 1 Gm. kaolin, 1 Gm., and pectin, 80 mg., in an aqueous vehicle. It is unflavored, contains no sugar.

Thaloctin Suspension is indicated in the treatment of acute enteritis, bacillary dysentery, diarrhea of the newborn, nonspecific diarrheas of infancy and childhood, and adjunctive treatment of ulcerative colitis.

Phthalylsulfacetimide, a sulfonamide of low absorbability and low toxicity, confines its antibacterial effect to the bowel contents and the mucosa into which it penetrates by diffusion. It is especially useful in cases where ulceration of the bowel has permitted organisms to invade the intestinal wall. Kaolin and pectin adsorb and detoxify putrefactive products and reduce the consistency of stools by their hydrophilic qualities.

For adults the dosage is three teaspoons three times daily, usually for five or six days. For children: one to three teaspoons three times daily according to weight. For infants: ½ to one teaspoonful three times daily.

Clinical Notes

By JAMES F. FLEMING, M.D.

Effective Blood Vessel Dilator

Roniacol, which is chemically related to nicotinic acid, is described in a recent article in the New York State Journal of Medicine as an effective blood vessel dilator of low toxicity.

Murphy, of the Peripheral Vascular clinic, Knickerbocker Hospital, New York, treated 40 patients with the drug—22 cases of peripheral arterial disease, 14 cases of thrombophlebitis with ulceration and four with angina pectoris associated with arteriosclerotic heart disease.

Of the 22 cases of peripheral arterial disease 17 were men, five were women; ages varied from thirty-eight to eighty-eight years. Symptoms had been present from a month to six years.

The roniacol therapy in this important group resulted in four showing excellent response, seven unequivocally improved, five showed fair improvement, and six no improvement.

In the second group of 14, Murphy found that three showed definite improvement after treatment, five showed partial improvement in the size of the ulcerations, and six showed no marked improvement.

Four patients with angina of effort constituted the third group. Attention to this particular indication was the outcome of more or less chance finding that one patient's angina, which developed subsequent to a lumbar sympathetic interruption, disappeared while taking roniacol. This encouraged the author to employ the drug in three other subjects. The results are as yet inconclusive but justify continuation of the trial. Toxic effects of the drug have been minimal.

Treating Diarrhea in Infants

Because the etiologic agent is not very often identified, diarrhea therapy in infants becomes a complex problem. To add to the difficulty is the fact that this condition may be rapidly fatal, and is sometimes epidemic.

A comprehensive plan of therapy is therefore indicated, and this is outlined by John Porter Scott, of Philadelphia, in *The Pennsylvania Medical Journal*, November, 1951.

He divides the treatment into three phases; repair of alterations in body fluids; prevention of water loss; and specific therapy.

For repair of body fluids, early treatment may consist only of withdrawal of food, and administration of 5% dextrose. More advanced cases require more active measures. The routine of Kaye, McCrory and Boggs is used for this purpose. The blood CO_2, Cl, Na and K are determined, and a lactate-dextrose mixture is administered by i.v. drip, followed by a transfusion or plasma. Later, dextrose, saline and calcium gluconate are administered. Butler's solution is also employed, consisting of lactate, sodium potassium, chloride and phosphate. The same fluids may be given by mouth when possible, and milk is begun later.

Restraining substances include carob bean flour in 5% suspension, 2½ to 3 ounces per pound of body weight; apple powder in 7½ to 10% suspension, which is pleasant to take; carrot soup; banana powder or flakes; nutramigen, protein milk and pectin-agar mixtures.

Restraining drugs which may be employed are pectin-kaolin mixtures, bismuth chalk preparations and opium in the form of paregoric or tincture of opium.

Calendar of Coming Meetings

American College of Radiology	Palmer House Chicago	Feb. 8
AHA Midyear Conference	Drake Chicago	Feb. 8-9
National Conference on Medical Service	Palmer House Chicago	Feb. 10
Wisconsin Hospital Assn.	Schroeder Hotel Milwaukee	Feb. 14
Arizona Hospital Assn.	Phoenix	Feb. 14-16
Georgia Hospital Assn.	Atlanta Biltmore Hotel Atlanta	Feb. 15-16
National Assn. of Methodists Hospitals and Homes	Statler Cleveland	Feb. 20-21
American Protestant Hospital Assn.	Hotel Statler Cleveland	Feb. 21-22
Rural Health Conference	Denver	Feb. 28-Mar. 1
Alabama Hospital Assn.	Russell Erskin Hotel, Huntsville	Mar. 14-15
Aero Medical Assn.	Statler Hotel Washington, D. C.	Mar. 17-19
American Academy of General Practice	Convention Hall Atlantic City	Mar. 24-27
Kentucky Hospital Assn.	Seelbach Hotel Louisville	Mar. 25-27
New England Hospital Assn.	Statler Hotel Boston	Mar. 24-26
Ohio Hospital Assn.	Hotel Cleveland Cleveland	Mar. 31-Apr. 3
Southeastern Hospital Conference	Atlanta Biltmore Hotel Atlanta	Apr. 16-18
Mid-West Hospital Assn.	President Hotel Auditorium, Kansas City	Apr. 23-25
Carolinas-Virginias Hospital Conference	Hotel Roanoke Roanoke	Apr. 24-25
Tri-State Hospital Assn.	Palmer House Chicago	April 28-30
Arkansas Hospital Assn.	Arlington Hotel Hot Springs	May 5-6
Assn. of Western Hospitals	Civic Auditorium San Francisco	May 12-15
Upper Mid-West Hospital Conference	Lowry & St. Paul Hotels, St. Paul	May 14-16
Texas Hospital Assn.	Shamrock Hotel Houston	May 20-22
New Jersey Hospital Assn.	Convention Hall Atlantic City	May 21-23
Middle Atlantic Hospital Assn.	Convention Hall Atlantic City	May 21-23
Catholic Hospital Assn.	Public Auditorium Cleveland	May 26-29
American Medical Assn.	Navy Pier Chicago	June 9-13
Biennial Nursing Convention	Auditorium Atlantic City	June 16-20
International College of Surgeons	Conrad Hilton Chicago	Sept. 2-5
American Hospital Assn.	Philadelphia	Sept. 15-18
American College of Surgeons	Waldorf Astoria New York City	Sept. 22-26
American Assn. of Medical Record Librarians	Shoreham Hotel Washington, D. C.	Oct. 13-17

Scanning the News

Noted in Brief

Officers of the new joint commission for the accreditation of hospitals are: Dr. Gunnar Gundersen, La Crosse, Wis., member of the A.M.A. Board of Trustees, was elected chairman of the commission; Dr. Roy Sloan, Chicago, of the American College of Physicians, was named vice chairman and Stewart K. Hummel, Joliet, Ill., of the A.H.A., treasurer.

• • •

Television will soon control air traffic at London Airport. Messages and maps are to be transmitted between ground radar operators and traffic-control officers to speed up air traffic control.

• • •

An area health monitor, an alarm which is sounded when atomic radiations endanger health and life is announced by General Electric. Installed in atomic energy plants, water works, laboratories, hospitals and other places where records of gamma or x-ray radiation must be made and kept, the alarm will measure and record the ionizing potential of gamma rays within the area.

• • •

Man may at last be on the track of solving the cold light of the firefly according to a report at the AAAS meeting in Philadelphia. Discovery of two new types of light-giving chemicals produced by a luminescent living organism were announced. The new chemicals give off their "cold light" simply by coming in contact with oxygen or air.

• • •

Lead Glass Fabric and Hospital Bed Chair Described in J.A.M.A.

Reported in the January 12, J.A.M.A., is a gown of lead glass fabric, designed for protection against x-ray radiation and beta radiation of atomic fission products.

Advantages of the gown (which has proved successful) over existing protective devices are: its complete protection of all exposed parts of the body; flexibility; durability; a weight of only 10½ pounds which is evenly distributed over the body; and cleanability, since the garment may be washed with soap and water.

Lead glass material may be used as a curtain to block off radiation in a room where superficial therapy is given or in a radiographic room.

In the same issue a new type of folding bed chair which will permit a recuperating patient to sit upright in a hospital bed without the effort entailed in moving out of bed and into a chair, is described. Devised by Dr. Hugh T. Jones, St. Vincent's Hospital, Los Angeles, the chair has been used for elderly patients following injury or surgery, those with heart disease, and in cases where bed rest is essential and yet a prolonged upright position is also desired.

The new chair has no seat. The patient sits on the side of the bed and the chair is placed behind him. Its supportive position is maintained by fastening the chair to the bed. Downward extensions of the arm rests are attached by screw clamps to the angle iron beneath the mattress.

Students "Farmed" Out to Country Physicians

"Farming" senior medical students out to country doctors is showing good results at Duke University. The program is to help improve rural health by encouraging students to enter general practice.

The students serve a minimum of two weeks tour of duty with a small town or country doctor in North Carolina (these physicians are all instructors in general medicine practice at Duke.)

Dean W. C. Davison who instituted the program commented, "the program gives insight into the problems of the country doctor on a give-and-take basis. These students learn to examine, diagnose and treat, thus meeting the principal problems confronting a doctor in rural practice.

• • •

Conditioner Restores Soil Productivity

Above: Dr. R. M. Hedrick, Monsanto Chemical Co. Research Laboratories, compares a carton of Krilium with the peat moss needed to condition 100 square feet of garden.

A soil-conditioner, called Krilium, which converts non-productive into productive soil in the matter of hours was demonstrated by Monsanto Chemical Co. at the AAAS meeting in Philadelphia.

The chemical restores the physical structure of the soil to its proper consistency thus enabling plants to obtain the optimum amounts of oxygen, water and nutrients from the soil.

Under extensive testing for the past three years, the chemical indicates that a revolutionary era in agriculture is in the offing.

One pound of Krilium (it is a powder form) is reported to have essentially the same effect as 200 pounds of peat moss or 500 pounds of commercial compost. The current average price of peat moss is four cents per pound, commercial composts sell at two and a half cents.

Krilium will sell at under two dollars a pound in its initial production stages. However, it is still in the developmental stage and will not be on the market in substantial quantities until 1953.

use CARTRIDS

for pipette accuracy
in antibiotic injections

Premeasured doses for a wide range of antibiotic therapy are now available as Cartrids. Complete with plunger and diaphragm, a Cartrid is easily inserted into a permanent metal-type syringe, ready for immediate and economical use. Breakage of glass syringes is eliminated; the preparation of equipment, minimized.

Cartrids are supplied as follows:

'Duracillin A.S.' (Procaine Penicillin—G in Aqueous Suspension, Lilly), 300,000 units per Cartrid

'Duracillin A.S.,' 600,000 units per Cartrid

Dihydrostreptomycin Sulfate Solution, 0.5 Gm. per Cartrid

'Duracillin A.S.' (300,000 units) in Dihydrostreptomycin Solution, containing the equivalent of 0.3 Gm. dihydrostreptomycin base, as dihydrostreptomycin sulfate.

Procaine Penicillin—G. in Oil, 300,000 units, with Aluminum Monostearate

Detailed information and literature on Cartrids are personally supplied by your Lilly medical service representative or may be obtained by writing to

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high potency

PROLONGED EFFECT

...get BOTH with this new penicillin product

A unique combination of penicillin G procaine (600,000 units per cc.) and buffered penicillin G potassium (200,000 units per cc.), ABBOCILLIN 800M provides both the high initial peak required in the treatment of many infections, plus an effective maintenance level for 48 hours.

Studies show that penicillin concentrations in the range of 5 units per cc. can be expected between one and four hours after injection of a single 1-cc. dose, thus providing maximum killing power of susceptible organisms and assuring an adequate concentration of penicillin at hard-to-reach infection sites.

The repository nature of ABBOCILLIN 800M affords an injection schedule as infrequent as 1 cc. every 48 hours in the treatment of mild to moderately severe infections. This means added convenience for the physician, less discomfort for the patient.

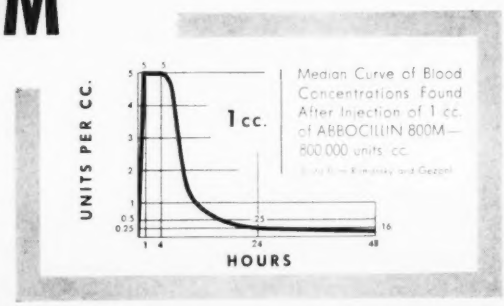
Unit for unit, ABBOCILLIN 800M is economical, too. Silicone-treated vials prevent waste. Supplied in 1-cc. and 5-cc. vials, singly and in boxes of 5 vials.

Abbott

Abbocillin 800M

Penicillin G Procaine and Buffered Penicillin G Potassium for Aqueous Injection, Abbott

800,000 units per cc.



118th meeting held in Philadelphia

REPORT FROM THE AAAS

Growth Determination, Arteritis, Salivary Cholesterol in Body Economy Discussed in Medical Science Section

Composition and Crystal Structure of Teeth

Dr. Albert E. Sobel, Head Department of Biochemistry, Jewish Hospital of Brooklyn—Studies in animals showed that the mineral composition of growing teeth can be regulated within wide limits by the diet and that this composition is related to caries susceptibility.

Crystallographic studies indicate that there are differences not only in caries susceptibility and chemical composition, but that there are also two types of crystal structure.

In the course of studies other interesting discoveries have been made. Experiments indicate that one can prevent the death of the mineralizing power of bone in solutions of table salt by adding small amounts of calcium. Moreover, calcium has the ability of reviving bone which has been poisoned by various metals.

Controlling the composition of the mineral matter and the degree of mineralization of teeth are important forward steps in the production of sturdy, caries free teeth. The control of the degree of the mineralizing power of the bones will find application in bone banks, and a new approach is indicated for the removal of radioactive elements and lead which lodge in the bone.

Arteritis

Dr. Russell L. Holman, professor of pathology, Louisiana State University School of Medicine, New Orleans—The experimental evidence suggests that the cause of arterial disease is in fat metabolism which is more or less independent of heredity, age, sex, hypertension, hypersensitivity and hypercholesterolemia. The primary injury to the arterial wall is caused by the peroxidation of one or more unsaturated fat acids but before this occurs one or more metabolic "safety valves" has to fail.

Associated Evidence

S. R. Gerber, M.D., LL.B., Coroner of Cuyahoga County, Cleveland, Ohio—One of the most complex of medicolegal problems is that of establishing accurately or beyond a reasonable doubt when death occurred. There are many theories or hypotheses, scientifically or practically sound for estimating the time interval elapsed after death.

The medicolegal expert learns to be wary of relying completely on any set of rules for estimating duration of death and evades making dogmatic statements based on such findings alone. Experience teaches that all such findings should be weighted against the associated evidence and where discrepancies occur and rely more on the conclusions reached from the analysis of the compiled associated evidence.

Associated evidence includes anything tangible or intangible which may accompany, be related to, connected, coupled, implicated or concomitant with the subject under investigation.

Growth Determinations for the Physician

Charles Weor Goff, M.D., Hartford, Conn.—A working acquaintance with developmental normals would be of great value to every physician should he see fit to devote some time to them.

In addition to weight and height, bone age is studied. Maturation plates are taken of both hands and wrists. In this regard we have begun to do plasma alkaline phosphatase determinations and hope it will assist in placing growth values in our various disease categories.

Age at menarche or spermatogenesis is recorded through interviews with parents or direct questioning of the individual. Pelvic x-ray studies can be used in this regard. When the iliac crest epiphysis first appears one can be fairly sure it coincides with these occasions. Somatotype or body build is determined by photogrammetric methods.

Scoliotic x-ray studies are taken with the individual standing, back against the Buckey plate holder and lower extremeties placed together. Views, bending to left and right plus laterals afford ample means of measuring the rates of vertebral growth, effects on the vertebral column of soft parts growth and anomalies of development.

Orthoroentgenograms are taken according to our modification of Green and Anderson's technic.

Dental maturation x-rays studies and eruption patterns are taken of each child who is suspected of some delay in bone growth. The two systems parallel each other.

Meaning of Cholesterol in Human Saliva

Dr. Frances Krasnow, Director of Research, Guggenheim Dental Clinic, New York—Preliminary experiments point the way for new approaches to the role of salivary cholesterol in the body economy.

In observations on 239 cases, the medically as well as dentally "normal" individuals showed an average of 7 milligrams per 100 cc. of saliva, while that for the abnormal series is 11 milligrams. If subdivided, the group without dental involvement but suffering from systemic ailment discloses mean of 9 milligrams, those with tooth malfunction only portray an average of 11 milligrams whereas subjects with both dental and systemic shortcoming give the much higher value of 13 milligrams.

Differences in cholesterol content may become a diagnostic tool in some respects more easily utilizable than its blood counterpart.

See Symposium on Arteriosclerosis on pages 13 and 14

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From the AAAS

SYMPOSIUM ON ARTERIOSCLEROSIS

Aging of Homeostatic Mechanisms

Nathan W. Shock, Section of Gerontology, National Heart Institute, National Institutes of Health, P.H.S., F.S.A., Bethesda, Maryland and the Baltimore City Hospitals, Baltimore, Maryland—Age changes occur even in animals devoid of circulatory systems; such changes can be demonstrated at a cellular level, and even in man there is evidence of age changes that cannot be accounted for in terms of structural changes in the vascular system alone.

The experiments of Lansing on the rotifier, a minute parthenogenic aquatic animal, have demonstrated an increase in the amount of calcium concentrated at cell surfaces. Removal of the accumulated calcium increased the life span by 50 percent. It has also been shown that the amino acid composition of the cellular proteins may change with age.

In our laboratory, Dr. Luther E. Smith has compared intravenous glucose tolerance curves in individuals of different ages. With increasing age the time required for the blood sugar level to return to basal level progressively increased.

A part of the delayed recovery of blood glucose levels may be due to changes in the capacity of the renal tubules to reabsorb glucose, but the delayed response in the aged cannot be assigned to any single process but is a result of impaired integration of the mechanisms for control.

Studies carried out in our laboratory with the collaboration of Mr. Marvin Yiengst have indicated that with increasing age there is a small but statistically significant reduction in the average pH of the serum under resting conditions, that is, the blood becomes progressively more acidic.

The administration of acidifying or alkalinizing substances produces a temporary shift in the acid-base equilibrium of the blood. In young adults recovery is affected within a period of 8 to 10 hours. Aged subjects, however, may require 24 to 48 hours for readjustments to normal conditions.

Age differences in response to other physiological stresses, such as changes in temperature, changes in posture, response to exercise and so forth, could well be cited. The common factor to all these processes is the increased time required for attainment of equilibrium in older people.

Ballistocardiography in Coronary Artery Disease

Benj. M. Baker, Jr., Wm. R. Scarborough, M. L. Singewald, R. E. Mason, and F. W. Davis, Jr., with the technical assistance of Salle A. Lore and Patricia Menzies—By the time that coronary artery disease has progressed sufficiently to produce illness in its victims the average physician can make the diagnosis with reasonable accuracy on the basis of signs and symptoms and without the utilization of precise instruments such as the electrocardiograph. The disease at this stage of its development usually reveals itself as angina pectoris or coronary thrombosis. However, the disease may appear in a disguised form and then the diagnosis may be difficult even for the most experienced.

Electrocardiograms are abnormal in only 41 percent of patients with unmistakable coronary artery disease. A simple, practical method for studying the mechanical pumping action of the heart is the ballistocardiograph. The ballistocardiograph is a specially designed table on which the patient is allowed to lie at rest. The table moves in response to the movements of the patient's body produced by the pumping action of the heart and the flow of blood. The record of the table's movement, called a ballistocardiogram, furnishes the trained observer information about the character and strength of the heart's beat.

The authors have obtained ballistocardiograms upon 274 patients with either angina pectoris or a history of coronary thrombosis. The records are abnormal in 76.6 percent of those patients while electrocardiograms are abnormal in only 40.8 percent.

As a comparison ballistocardiograms have been obtained upon 300 individuals, comparable in age, who have no evidence of heart disease. 31 percent of those have abnormal ballistocardiograms and 3.3 percent have abnormal electrocardiograms.

The exact meaning of these findings is not yet known. Final interpretation must await a more thorough understanding of ballistocardiography. The most that can be said at present is that healthy youths have completely normal ballistocardiograms and a high percentage of patients who are known to have coronary artery disease have abnormal ones. Between healthy youths and patients with coronary artery disease stretches the normal population and it is obvious that some of the individuals in this normal population are in the process of developing coronary artery disease. Promising methods for the treatment of this condition make it important to detect these individuals at the earliest possible moment.

The authors results indicate that abnormal ballistocardiograms occur in a high percentage of patients with coronary artery disease and that abnormal ballistocardiograms occur more frequently than do abnormal electrocardiograms in such patients. In addition, a small sample of the normal population contains a significant number of persons with abnormal ballistocardiograms. Whether or not these individuals will eventually become heart disease patients must await the results of further research.

Etiologic and Pathogenetic Factors in Arterial Disease

L. L. Waters, M.D., G. I. DeSuto-Nagy, M.D., and W. B. MacAllister, M.D., Dept. of Pathology, Yale University School of Medicine—Factors referable to the arterial wall and to lipid metabolism are of importance in the etiology and pathogenesis of arteriosclerosis in man.

Experiments with allylamine demonstrated that arterial hypertension is not essential for arterial necrosis. They also provided a standard experimental obliterative lesion of the coronary arteries, fully developed within days to weeks.

Hypertensive episodes produced by injections of epinephrine, other pressor amines or of renin lead to necrosis of the coronary and visceral arterioles of normal dogs if the mean femoral arterial pressure is maintained in the range 220-280 mm. Hg. for approximately 30 minutes. The lesions are morphologically comparable to those seen in the arterioles of man in instances of severe hypertension and renal failure. The animals do not have renal failure.

While arterial hypertension may directly injure arteries it may in some instances lead to hemodynamic changes in the venous circulation that are also of importance in this regard. Further, the presence of increased systemic or

organ blood volume may constitute a hazard to the arterial wall even without the adjunct of elevated arterial pressure.

It appears from experiments that blood lipids, whether injected or fed, do localize in quantity at the sites of arterial injury, but they do not then set up a progressive foam-cellular process in the arterial wall.

The Biology of Arteriosclerosis

Dr. Eli Moschcowitz, Consulting Physician, Mount Sinai Hospital, New York City—Clues as to the genesis of arteriosclerosis can be gained by studies of comparable lesions of other portions of the vascular tree, namely the veins, the capillaries and the cardiac chambers, and finally, studies on the incidence of arteriosclerosis in the lower animals are significant.

To our view the hyperplasia of the intima, the elastica and of the medias are the omnipresent lesions of arteriosclerosis, and for this reason the term hyperplastic arteriosclerosis is applicable and serves to distinguish it from other brands of arterial thickening.

The arteries do not attain their maximum of development at birth, like most organs, but the intima and elastica grow progressively from birth to old age. It is well known that at birth the intima is exceedingly thin, so that the endothelium lies directly on the elastica interna, which is a single delicate layer. As age advances, the intima thickens by a growth of collagenous tissue, until in old age it becomes fairly wide and is frequently infiltrated by hyaline substance. The media also increases in thickness with the growth of the body.

Hyperplasia of the intima and of the elastica bears all the earmarks of a compensatory process, and the evidence is convincing that it represents an adaptation to the progressive increase of intra-arterial pressure that normally occurs from birth to old age or, if by chance there is no perceptible increase, to the prolonged maintenance of the normal intra-arterial pressures. There are many proofs that normal intravascular pressure is the dominant factor in the production of hyperplastic arteriosclerosis.

The fact that hypertension represents only an exaggerated normal function is not sufficiently appreciated. In normal circumstances gross arteriosclerosis in the vessels of the greater circulation is practically omnipresent, and as Monckeberg has shown it manifests itself in about the twentieth year. It may be concluded, therefore, that it requires this span of living for the effect of normal intra-arterial pressure to produce arteriosclerosis sufficient to be observed grossly. When hypertension is superimposed, the arteriosclerosis is more widespread and is more intense as manifested in malignant hypertension or nephrosclerosis.

Hypotension decreases the incidence and intensity of arteriosclerosis. It is noteworthy that in cases of active tuberculosis, especially with emaciation, arteriosclerosis is not conspicuous, age for age.

It is believed that the evidence thus far submitted rendered inescapable the conclusion that the normal intravascular pressure and its increased gradient, hypertension, are the dominating factors in the production of hyperplastic arteriosclerosis and that it represents a biologic progression of the normal hyperplasia of the intima and of the elastica that begins at birth. The following equation may thus be formulated: arteriosclerosis = intra-arterial pressure × time.

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This is the last in a series of articles on the Hospital Library

CONTRIBUTIONS of the MEDICAL LIBRARY ASSOCIATION

By Helen G. Field*
National Institute of Mental Health
Baltimore, Maryland

IN the past year this journal has carried accounts of the Medical Library Association, its history, aims, and activities. A brief summary of some of its contributions may be of special interest to those concerned with hospitals.

First might be mentioned the Association's work in setting up standards for various special types of medical libraries—the hospital library, the pharmacy library, the nursing school library, and the medical school library. These standards offer specific practical guidance in matters of buildings, books, budgets, and librarians. A great deal of thought and cooperative effort go into evaluating periodicals for the benefit of small libraries which must make the best of limited funds.

Standards for Education and Achievement

The Association also sets standards for education and achievement in medical librarianship. Work is being done to improve and expand the curricula in library schools, and to provide opportunities for supervised experience in medical library work on an internship basis, with time for advanced study. A limited number of scholarships are offered to students interested in specializing in medical library work. Certification, at three different grades, corresponding to approved levels of medical library training, is granted by the Committee on Standards for Medical Librarianship. The Association maintains a placement service for its members, and a Personnel Survey Committee investigates employment practices and salary standards in medical libraries, comparing them with those in other types of libraries.

Opportunities to Members

To its members the Association offers the opportunity for discussing problems and exchanging ideas in meetings. There are 360 institutional members, and around 650 professional, associate, sustaining, and honorary members, among whom are many physicians. During the annual meeting a member has the opportunity to present topics for consideration by two, or twenty, or two hundred or more fellow librarians in medical fields. Usually, conferences of special groups are held simultaneously. Regional group meetings of medical librarians in Southern California, the San Francisco Bay Area, the Midwest, and New York are held throughout the year.

For the last three years the Rockefeller Foundation has offered fellowships to foreign students in medical librarianship. These students, by the information they bring regarding their own home libraries, as well as by their stimulating questions, enrich the Association during their visits.

One of the most important contributions is the Exchange, a clearing-house through which books and journals are moved from libraries where they are unwanted duplicates to other libraries which badly need them. The benefits of duplicate material are not restricted to member institutions. Much material has gone to foreign libraries, via UNESCO and the United States Book Exchange, and, after the destruction by fire of the medical collection of the University of Chile, some 56,000 volumes were made available as replacements by North American medical libraries.

It has been possible in some cases to obtain lower subscription prices of certain European medical journals ordinarily prohibitive for small libraries, to arouse interest in bibliographical standardization, and to encourage the development of needed services. The Association publishes checklists of periodicals available from various countries, and cooperates in the preparation of such standard tools for the library world as *Union List of Serials*. It is active in investigating new publication media, such as microcards.

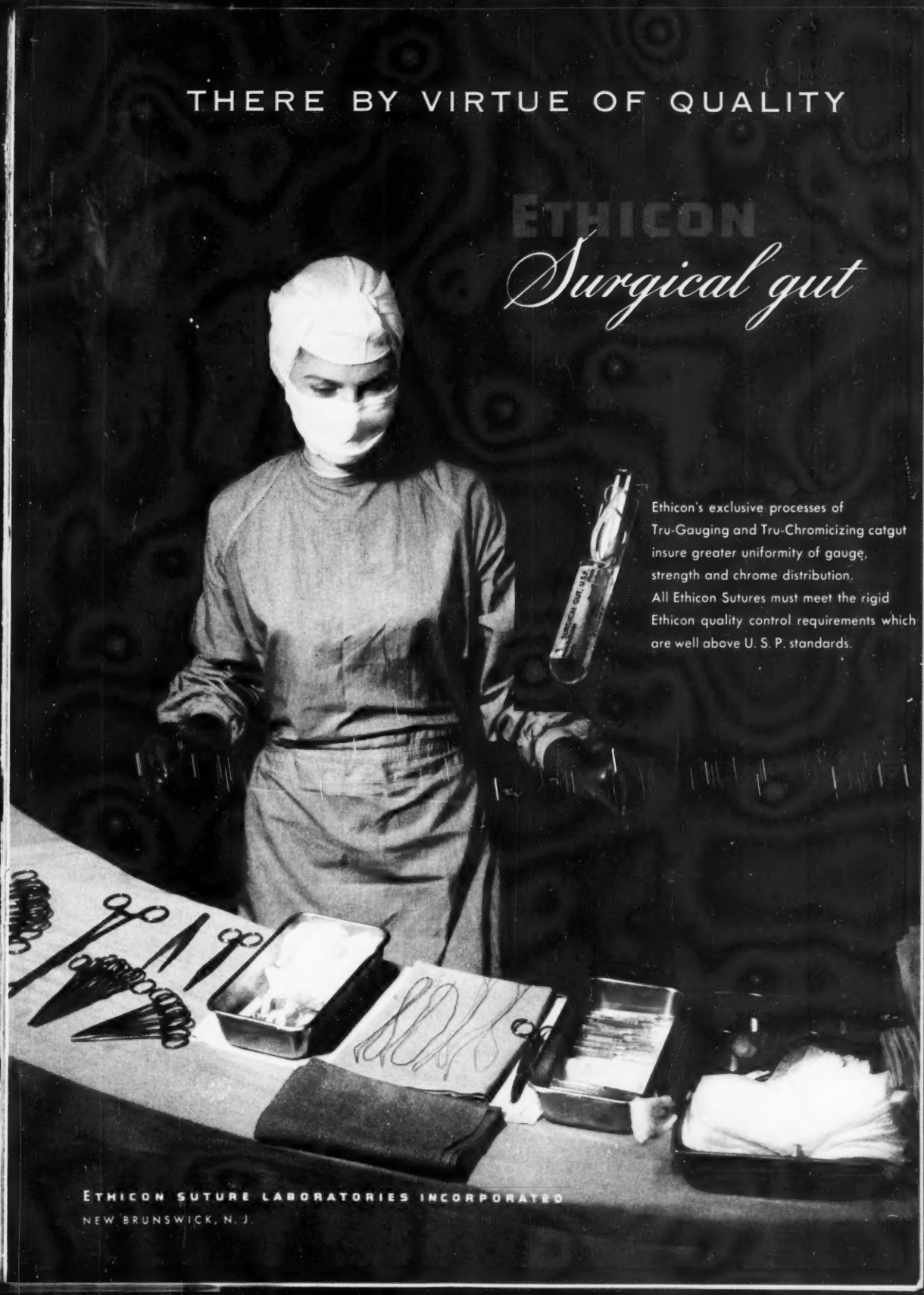
Bulletin of the Association

The Bulletin of the Association is a quarterly journal, which carries general news and notices, scholarly papers in medicine and bibliography, discussions and discoveries in library methods, and the proceedings of the annual meetings. A *Directory of Medical Libraries Belonging to the Medical Library Association* has recently been published. For each of the 360 libraries is given the date it was founded, its source of support, size of staff, size of the collection, special subject collections, classification system, special services available, and the name of its librarian. A *Handbook of Medical Library Practice* was first published in 1943, and has three times been reprinted.

Cooperation with Other Organizations

Finally, there is the cooperation between the Medical Library Association and other organizations, national and international. The Association has sent representatives to meetings of the American Documentation Institute, the Council of National Library Associations, the International Federation of Library Associations, and UNESCO's Coordinating Committee on Abstracting and Indexing of Medical and Biological Sciences. It stands ready at all times to participate in undertakings designed to improve the facilities and increase the services provided by scientific libraries in the field of medicine.

* Public Relations Officer of the Medical Library Association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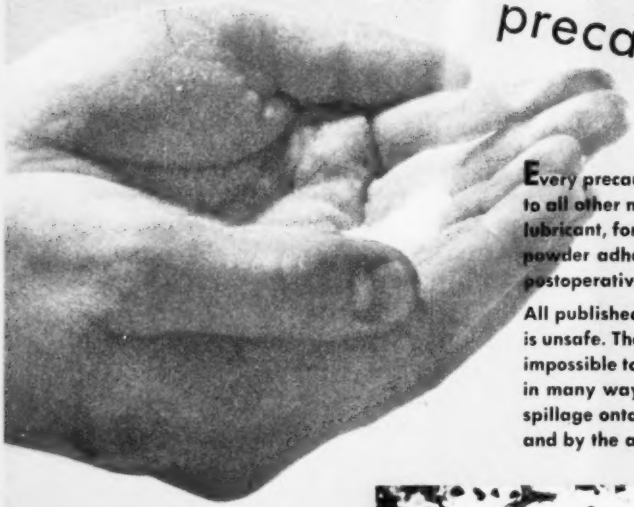

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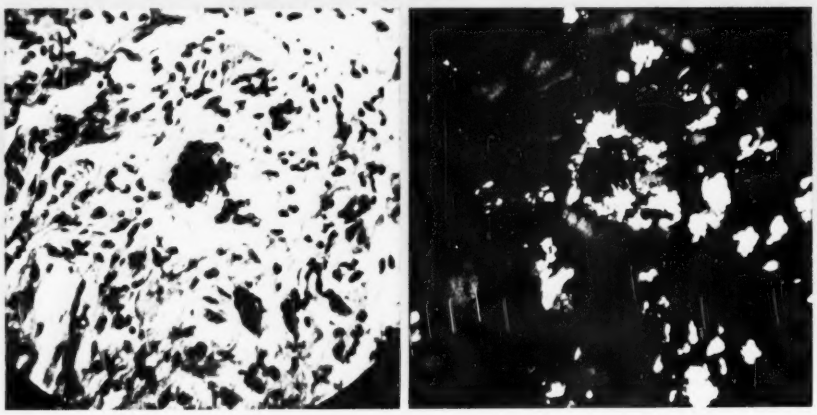

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Report from the American Academy of

Dermatology and Syphilology

Left to right: Dr. Donald M. Pillsbury, Co-Medical Director Skin and Cancer Hospital, Philadelphia; Consultant United States Public Health Service; Consultant to Surgeon General, U.S.A.; Professor of Dermatology and Syphilology, University of Pennsylvania and Graduate School; out-going president. Newly elected president Dr. C. Guy Lane, Boston. Newly elected vice president Dr. Michael H. Ebert, Chicago. Re-elected secretary-treasurer Dr. John E. Rauschkolb, Assistant Clinical Professor of Dermatology and Syphilology, School of Medicine, Western Reserve Univ., Cleveland. Outgoing vice president Dr. J. Lewis Pipkin, Associate Professor of Dermatology and Syphilology, Post-Graduate School of Medicine, Baylor Univ., San Antonio, Texas. Re-elected assistant secretary-treasurer Dr. James R. Webster, Chicago.

Professional Dermatoses in Physicians

Dr. Ervin Epstein, Assistant Clinical Professor of Dermatology, Stanford University Medical School—Doctors are subject to skin diseases, and are not very good patients.

The lay person does not expect his physician to be subject to the same ills as the ordinary workingman, but there is probably no occupation that subjects a worker to more danger from strong chemicals or exposes him to as many chances of infection as medicine.

One of the most common causes of dermatitis in physicians is scrubbing for surgery, with the use of strong detergents, antiseptics and alcohol. Some physicians are found to be sensitive to rubber gloves, used in surgery and examinations, or to some element in the powders used. Others are sensitive to local anesthetics, procaine being the most common.

Physicians also can acquire infections from contact with various contagious skin diseases, but this is comparatively rare, possibly due to cleanliness and personal care.

Dermatitis caused by exposure of the skin to radiation from X-ray is a hazard the physician encounters, but proper safety measures could eliminate this danger.

ACTH, Cortisone in Dermatology

Dr. Robert R. Kierland, Associate Professor, Dermatology and Syphilology, Mayo Clinic—ACTH and cortisone frequently give dramatic relief in eczema, but do not actually cure eczema.

The effects of these hormones in the eczematous groups are usually prompt and beneficial upon the pruritus and the inflammatory phenomena.

Frequently within relatively few hours the patient is relieved of his itching and he is once more comfortable. Later and within a few days the eruption itself subsides partially or completely.

The effects are frequently dramatic and to see a patient who for months or years has been tormented and ravaged almost continuously by his disease once again be a comfortable, pleasant and happy individual is one of the great satisfactions a physician may obtain.

However, the physician must weigh use of this treatment with the patient's condition, extent and duration of the disease.

Use of BAL in Chronic Chrome Dermatitis

Dr. Harold N. Cole, Jr., Senior Clinical Instructor, Western Reserve University, Cleveland—Chrome compounds such as chromic acid, chromates and bichromates, are very active chemically and are powerful skin irritants. They have extensive use in manufacturing processes including photoengraving, lithographing and photography, tanning of hides, in the textile and fur industries, in the manufacture of chromium pigments, in the furniture industry, in chromium plating, and the metal industry in cutting and rust preventing oils.

These compounds affect the tissue proteins, forming chemical compounds as they do in the tanning of hides. In strong enough concentration they corrode the skin and mucous membranes.

There is no specific treatment for chrome dermatitis. The problem is best approached by methods of prophylaxis, including the wearing of long rubber gloves and the use of protective ointments.

Intramuscular injections of BAL for chronic chrome dermatitis have proved of no value. A concentration of 3 per cent BAL in an ointment was used. Research with rabbits showed objective improvement within 48 hours and at the end of one week all of the animals showed 25 to

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Two mild cases were cured after two months and the other mild case, who still has occasional contact with chromates, is 75 per cent improved after two months of treatment. The final severe case did not tolerate BAL at the first application and the treatment was discontinued.

Newer Antibiotics in Venereal Diseases

Dr. Raymond C. V. Robinson, Instructor in Medicine, Johns Hopkins University School of Medicine—Although the newer antibiotics generally are effective in treatment of venereal diseases, penicillin and the sulfa drugs are still the most desirable drugs for treatment.

Though there is some disagreement in the over-all picture, there appears to be little doubt that cortisone, applied locally in the form of drops or ointment, exerts a beneficial effect when therapy is instituted early in syphilitic interstitial keratitis. If continued long enough, there may even result an apparent clinical cure.

The newer antibiotics have their indication where there is a hypersensitivity to penicillin. In the treatment of granuloma inguinale, streptomycin, aureomycin, chloramphenicol and terramycin are effective.

In treatment of chancroid, sulfathiazole and sulfadiazine constitute the treatment of choice. If evidence of healing is not apparent within a week, one of the antibiotics should be tried.

In treatment of lymphogranuloma venereum, the great bulk of literature describing the reaction of the disease to the sulfonamides seems to favor the use of these drugs for routine therapy.

Dr. Frederick Deforest Weidman (left), Professor of Dermatology and mycology emeritus, Medical School, University of Pennsylvania, receives placque from Dr. Donald M. Pillsbury. Dr. Weidman assisted Dr. Howard Fox in drawing up the constitution of the Academy upon its founding in 1937.

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Consumer-Sponsored Program Brings Two

Above: Manager J. J. Leipzig busy at his administrative duties was responsible for the Tigerton Cooperative plan.

MEDICAL authorities continue to be plagued by the lack of adequate hospital facilities and medical care for the non-urban sections of the country. The problem is twofold: It is often virtually impossible to obtain the initial capital to erect even a small hospital, and it is equally difficult to provide any incentive for physicians to locate their practice in a small rural community.

A partial solution to this problem may be the cooperative hospital and health association. Any mention of a cooperative plan immediately causes criticism—in that it involves contract medicine, with loss of choice of a doctor by the patient, and a tendency of a doctor on a salary to be superficial because he is certain he will receive remuneration.

Advocates of a cooperative association retort that a patient in a small community often has very little choice of a doctor anyway. Many also claim that whether a doctor's work is conscientious or not depends on the man himself, not on his method of remuneration.

The type of association in most common use is the producer plan—a pre-payment system controlled by the doctors, who are the producers of the service rendered.

The consumer-sponsored plan is a newer idea. Here, lay people have the authority to own and operate hospitals and to enter into contracts with doctors for the professional care of association members.

Cooperative plans are still in the embryo stage in this country. In some sections, doctors working in such a plan are not admitted to County Medical Societies. Most states have some type of restrictive legislation; many allow *only* the doctors to set up cooperative systems.

In 1947, the Wisconsin Legislature passed a law allowing consumer-sponsored plans in that state. J. J. Leipzig, who believes that "The way to bring doctors to the rural areas is to furnish them with a workshop," was instrumental in setting up two successful organizations in Wisconsin, at Wild Rose and at Tigerton. Tigerton, which Leipzig now manages, is an example of a working cooperative hospital plan.

To become a member of the Tigerton association you are required to take out a membership which costs $100. This is only an equity in the physical property, but unless you have this membership you cannot get health care. After securing a membership you are entitled to the coverage of the insurance—to the extent and at the rates found in the contract. The original $100 helps to pay basic salaries and furnishes the capital to set up the hospital.

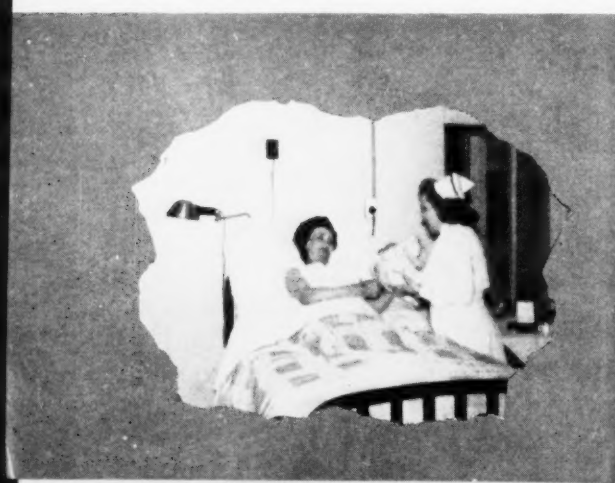
The People "Own" the Association

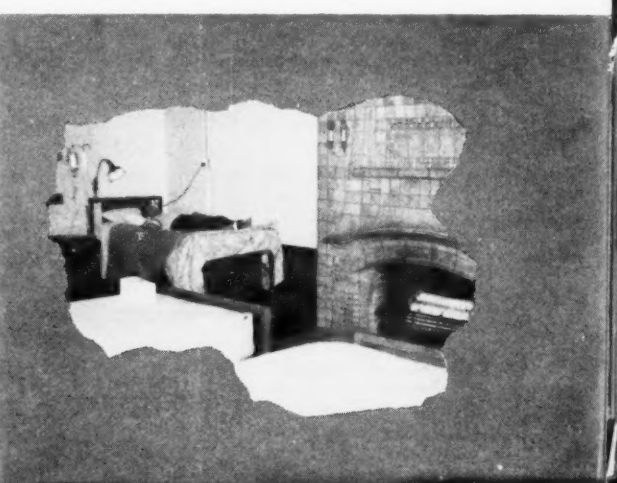
The people "own" the association, and the association, in turn, owns its own facilities and enters into contract with doctors for professional care of its members. For specified monthly rates, hospitalization and professional care is provided. This includes all office calls and preventive care.

The association hires the doctors at a base salary for which they provide care for the members only. They have their offices in the hospital and in addition to the membership service, can have private practice. In the two associations operating in Wisconsin, the doctors' private practice is about 75 percent of their total earnings.

Everything is furnished the doctors for their work. This includes bookkeeping, collections, and receptionist. For this and office space, they pay the association 20 percent of their income from private practice.

According to Dr. Richard M. Rogers, one of the staff





TO RURAL MEDICAL CARE PROBLEM?

Physicians and 30-Bed Hospital to Tigerton

members at Tigerton, the doctors do an amount of work probably equivalent to what it would cost the patient as a non-member. But he adds, "More important, the fact that the people of the community themselves own the hospital, has given us a wonderfully enthusiastic nucleus for our work."

The doctors work regular hours (barring emergencies). They have one and a half days a week off, and alternate nights and holidays on call. They work as a team in any clinic.

Two Physicians on the Staff

There are two doctors on the staff, a general surgeon and a general practitioner. They feel that having two or more doctors as a group eases the day-to-day strain of always being on call, and multiplies the efficiency of the doctors involved.

If the demand increases, more emphasis will be placed on specialty fields when the staff is enlarged. However, in small rural communities specialty fields are not covered as they could, or would be in cities.

An idea of the actual service to the community of such a plan can be seen in the contract of the Tigerton Association. The rate for a single head of a household is $3 per month. The head plus one dependent is $5 per month. From there, it is 25 cents for each minor dependent up to a maximum of $6.75 per month for the head of the house, wife, and four or more dependents. Additional adult dependents living in the same household are charged $4 per month.

Rates are reviewed from time to time by the board of directors and may be adjusted to meet any unforeseen rising costs. If rates exceed expenses, the excess is prorated and allocated to the credit of each member according to his contributions. However, this excess can be used for reserve funds or the expansion and improvement of the association's facilities.

Included in the contract are such benefits as hospitalization up to 62 days for each contract year, drugs, not exceeding $25 a year, and use of the operating room, delivery room, laboratory and other regular hospital facilities provided by salaried hospital personnel.

Other services are complete obstetrical care, specialist consultations with any staff doctor, and administration of vaccines, antitoxins and sera—to be rendered only at hospital headquarters.

When a member of the association needs emergency medical attention while away from the health center, he may file a claim for services ordinarily covered at Tigerton. He will receive $4 a day toward hospital board and room charges (not exceeding 30 days), up to $20 for miscellaneous services in a hospital, and up to $100 for medical and surgical treatment.

The contract also states the services *not* furnished within the association. Surgery of the brain and nervous system, dental care, and psychiatric treatment or consultation are specifically *not* included. Also excluded are treatment or hospitalization in tuberculosis, mental disease, venereal disease, or drug or alcohol addiction, after provisional diagnosis. No house calls are furnished by the association, but the doctors will make them in their own practice.

Before an association of this type can be set up the way must be cleared for its legality. In Wisconsin, the authority is in chapter 185.25 of the state Statutes—"Cooperative associations may be organized under this chapter without capital stock, exclusively to establish and operate in the state or in any county or counties therein a nonprofit plan or plans for sickness care, including hospital care for their members and their dependents through contracts with physicians, medical societies, dentists, dental societies, hospitals and others."

Tigerton—A Pattern for Future Hospitals?

The prospect for more cooperative hospital associations is subject to much debate. There can be many variations on the Tigerton plan—but the basic idea and program may well be an important consideration for hospitals of the future.

A little over a year ago Tigerton, Wis., a community of nearly 1,000 people, was without a doctor. The closest clinic was ten miles away—the closest hospital was twenty-five miles away. Today the community is served by two doctors and a 30 bed hospital that handles from 350 to 450 outpatients a month.

Despite criticism the cooperative plan *has* worked in Tigerton.

Photographs from left to right: (1) Nurse Kielblock hands a baby to its mother in one of the hospital's cheerful rooms. (2) One of the five bed wards. (3) Staff physician, Dr. Heise, takes an x-ray of a patient's forearm.

The Inner Voice

Administrator Barks Back!

Recently the "Inner Voice" trumpeted the slightly dyspeptic roar of some Board member who sounded more like a wounded bull than a rational human. He sounded so much like a member of the Board of a hospital which I formerly administered that I could not resist commenting on the picayunish concept of his ilk.

Their basic criterion is always—"Is the hospital in the black?" My particular Board member was opposed to the hospital when it was first built. His secret admission to his close cronies was "I would not use the hospital myself." His commentary at Board meetings alternated between "Where are we going to get the money?" and "Why is it that Dr. D---'s hospital down the street makes money?" Incidentally, he has never been known to actively support any drive for supplemental funds. Dr. D---'s hospital is a proprietary hospital operated by two physicians. Their own patients and patients of any other physician in the country are admitted. This hospital is principally used for the overflow from the non-profit hospital. In 1950 the latter institution had an occupancy of over 90 per cent. The Board, thanks to our pecuniary minded friend and his ilk, have been very reluctant to expand the voluntary hospital even though the need is apparent. This group can find irrelevant excuses to fit every pressure to build. To them it is spending money. For example, when it looked like we could get Hill-Burton funds, they did not want any of these XYZ!!—! blank Federal funds. They could raise their own funds. That was three years ago. They have not even attempted a capital fund drive since.

During a three year period I noticed that practically all the wealthy persons in the community went to an adjacent urban center for their hospitalization. Yet these same persons continually questioned why ten percent of the annual hospital bed days were for free patients. Obviously the patient load was principally that of the middle and low income group in the community. Parenthetically, while the wealthy went elsewhere, the domestic help of these individuals were taken care of in the community hospital—a number of these patients were free or part pay.

One of our Board members asked on one occasion why we didn't refuse to release patients, particularly O.B. patients, until their bill was paid. Aside from the moral factor,—this particular member was a Judge—he had apparently never heard of false arrest.

As to comparing a proprietary hospital with a non-profit hospital: The voluntary hospital must give broad community services. It does not limit its care, as does its proprietary neighbor, to the bed patient. In 1950 the voluntary hospital that I'm writing about had 28,000 outpatient visits. The average loss per outpatient visit was one dollar thirty seven. The community hospital has to provide extensive X-ray, laboratory, surgical and obstetrical facilities to meet every need of the community. In addition, this particular voluntary hospital has a blood bank, physical medicine and occupational therapy. Each of these activities assure the community of better and more accurate service. The proprietary hospital is concerned principally with providing the physician with a workshop and the patient a bed for which a maximum charge may be assessed. Objective proof of this statement is the relative amount of space devoted to services, clinical and diagnostic facilities. For this particular voluntary hospital there are 610 square feet overall to each bed. The proprietary hospital has less than half this figure—293 square feet. That gives a good idea of how much greater space is given over to community services, diagnostic and treatment facilities in the voluntary hospital. The actual bed space—that commodity for which the hospital can place a price tag—is in fact only about 20 per cent of the space of the entire hospital.

It appears to me that one of the greatest needs in the hospital field is an enlightened Board of Trustees. With all the courses for improvement of cooks, bakers, laundrymen, accountants, housekeepers and what nots, how about a series of courses to broaden the perspective of Board members?

- This is a meeting place for administrators and others with ideas, opinions and visions which too often are thought of and left unsaid. Contributions and comments are welcomed.

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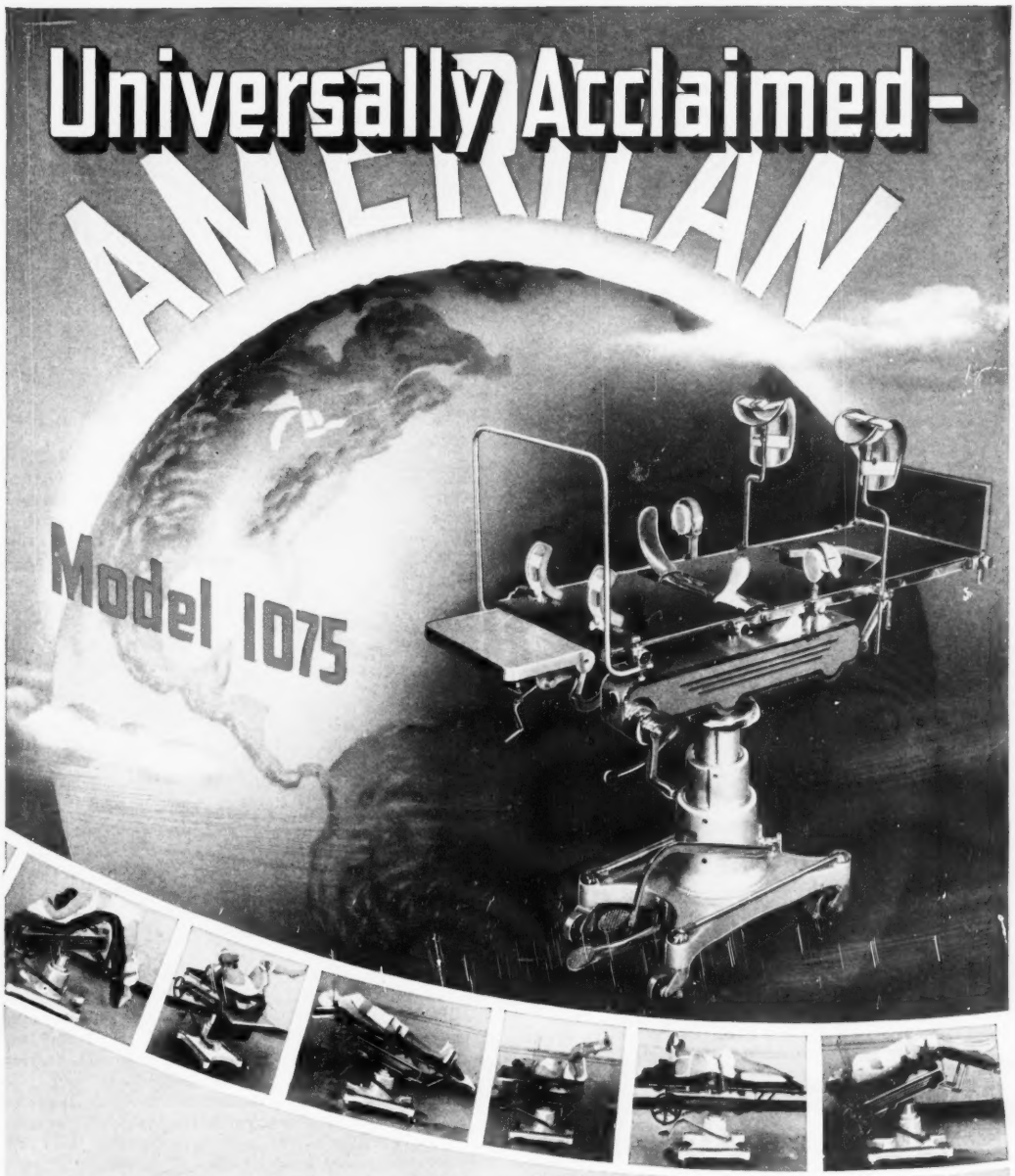

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AMERICAN COLLEGE OF CLINICAL ADMINISTRATORS

Newly organized Group Seeks to Establish Place for Administrator in Clinical Field

THE American College of Clinic Administrators held their first annual meeting in Chicago. Organized in 1950, the group will work toward establishing a place for the administrator in the clinical field.

In his presidential address R. J. Wilkinson, Huntington, W. Va., emphasized "that for successful operation of a clinic there must exist a close cooperation between the business office and the professional personnel. This leads to the reasonable conclusion that a trained administrator is necessary."

Mr. Wilkinson in reviewing the rapid changes in medicine said "To keep abreast of progressive changes, more and more physicians realize the importance of specializing and forming groups. With a group of physicians working together, each in his specialized field, duplication of overhead expense is eliminated and a great saving is made by application of sound management principles, insuring better purchasing, personal relations, public relations and financing—resulting in increased income for the group."

"It should be obvious that a trained administrator can render a superior type of service, thereby assuring the successful operation of the clinic."

In discussing the progressive policy which the College must pursue to stimulate interest among physicians, Mr. Wilkinson suggested:

1. Approval by resolution of a collegiate course of study for four years for administrators.

2. Those affiliates having completed a college course with a degree serving as members for two years before being granted full Fellowship after submitting a thesis to be prescribed. All others associating with the ACCA should serve two years as nominees before being admitted to membership, with attendance at meetings being compulsory.

3. The organization by the College of an Association of Clinic Physicians and Surgeons, which group would meet conjointly with the College yearly and the publication by the two groups of a Journal of Clinic Medicine and Administration.

4. The establishment of a national medical service plan commission, to be comprised of representatives from the AMA, AHA, American Dental Assn., ACHA and the ACCA. This group would serve as an advisory board.

In his discussion, "The Advantages of a Clinic Having its Own Hospital Facilities", Charles Heath, Paris, Ill., said the chief advantage was the availability of beds. In small towns this practice developed from necessity where there were no hospital facilities.

Benefits from having physicians' offices in the hospital are numerous. They constitute a source of income from unused space, increased use of diagnostic and therapeutic facilities, pools of nurses, etc. Economy can be practiced with availability of a better quality of workers and opportunity to buy supplies in larger quantities. The patient benefits from seeing his physician frequently, having more opportunity for physician consultation and by getting reduction in cost of care.

Advantages to the physician include having adequate facilities and complete medical records available, more vacations and opportunity to stagger hours.

Dr. Malcolm T. MacEachern, Chicago, outlined the education of clinical administrators. "He must have knowledge of business, medical administration, medical economy, practical phychology and sociology plus use of management skills and technics of an executive plus ethics, skill and patience."

Said Dr. MacEachern, "University training in hospital administration is very new. The first program was set up at the University of Chicago in 1934. Northwestern's program was established in 1944. The remaining ten have been set up in the last five or six years.

"It will be some time before the need is met, but the trend is toward trained administrators and in twenty to twenty-five years it will be the rule rather than the exception.

"There is no special university program for clinical administrators at present. However, the University of Iowa offers electives in clinical administration in their program which should be worth watching."

Blue Shield, since its organization in 1946, has grown from nine plans to 78 in 42 states, the District of Columbia, Puerto-Rico, Hawaii and eight Canadian provinces. Enrollment stands at approximately 22 million according to Frank Smith, Executive Director, Blue Shield Plan, Chicago.

Two significant trends in Blue Shield have been (1) catastrophic coverage. This began in California and has been picked up by several other states. (2) deductible coverage on long term or chronic illness. Under this coverage the patient is responsible for the first $100, $200 or $300 then the plan takes over paying about 75% of the rest.

Mr. Smith suggested administrators talk to Blue Shield representatives in their area about contracts and immediate problems. "Clinics might well serve as guinea pigs in cost experiments to improve and better insurance plans," he said.

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S-R-D, 1 Gm.: Each vial contains 300,000 units of procaine penicillin G, 100,000 units of buffered crystalline sodium penicillin G, and dihydrostreptomycin sulfate equivalent to 1 Gm. of dihydrostreptomycin base. When 2.2 cc. of diluent is added, this provides sufficient material to permit withdrawal of 2 cc. from the vial for a single-dose injection.

S-R-D, ½ Gm.: Each vial contains 300,000 units of procaine penicillin G, 100,000 units of buffered crystalline sodium penicillin G, and sufficient crystalline dihydrostreptomycin sulfate to represent ½ Gm. of dihydrostreptomycin base. When 1.5 cc. of diluent is added, this produces 2 cc. of material for injection.

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MEDICAMENTA VERA

Special Reports

Useful to Hospital Management

By David H. Spanier
Hospital Accounting Consultant
Division of Medical and Hospital Resources
Public Health Service

THE coordination and efficiency of internal department operations in hospitals can be greatly improved if administrative heads of departments and the hospital administrator are currently furnished such special reports as will best emphasize cost control and provide analyses of accounts which may disclose waste, inefficiency and poor supervision.

Hospital administrators, especially those not trained in accounting, may not be familiar with what special reports the business office can furnish; therefore no requests for them may ever reach the hospital accountant.

To obtain such managerial aids as the business office is in a position to furnish, administrators should request reports of a special nature, such as "Bad Debts Charged Off", classified by physician or "Purchase Discounts Lost". There will come to mind many more special or unusual reports which management may utilize as a form of control technic or to evaluate departmental operating efficiency and economy.

Classifying Bad Debts

By Form A, there is illustrated one method of classifying bad debts for a six month period by name of physician. This form has three columns, for name of physician, name of patients and amount of bad debts. Provision is made thereon for obtaining a sub-total for each doctor and a grand total for all doctors. Such information is readily available from the accounts receivable records in the business office.

Bad Debts Charged Off
(Classified by Physician)

For the six month period ended June 30, 1951

Name of Physician	Name of Patient	Amount of Bad Debts
Dr. L. M. Curem	Allen, J. L.	$200.00
	Budde, T. R.	75.00
	Cort, Jack	60.00
	Sub-total (for each doctor)	$335.00
Dr. V. G. Diagnosis		
	Grand Total	$1,845.00

Form A

Conventional methods of classifying bad debts are useful to the business office in determining when the accounts should be placed in the hands of a collection agency or referred to an attorney for collection. However, the classification method shown by Form A will provide management with one convenient technic for obtaining first a list of doctors whose patients are slow pay, second, by giving management a method of obtaining assistance in collecting the accounts from such patients and third, by calling this to the attention of the doctors, they may offer to help the hospital in having their patients make the necessary arrangements for payment of their hospital bills before they are hospitalized.

Control of Hospital Finances

Another management aid in control of hospital finances is a list of purchase discounts lost. When we consider that 40% of each dollar spent for hospital operation is for supplies, materials, food and equipment, the amount of purchase discounts in a year can amount to a considerable sum.

Purchase Discounts Lost
for June, 1951

Paid to	Amount of Check	Amount of Purchase Discount Not Taken
Abbott Grocery Co.	$257.12	2.10
Brown Hospital Supply Company	318.00	6.36
Total	$4,615.00	$64.12
Total Discounts *Taken*		$27.09

Form B

There is illustrated by Form B one means of listing purchase discounts lost by name of creditor. A cursory examination of such a list will tell at a glance the amount of discount lost on each purchase, arranged in order by name of creditor. It is important that special reports such as these contain facts at a glance which can provide an administrator with control methods which will safeguard hospital assets and provide greater economy in operation.

A large percentage of patient income is represented by patients' accounts receivable. Frequently it happens that some hospital charges which were received in the business office after the discharge of the patient were

not shown on the patient's statement. An analysis of such late charges, showing the name of the patient, the department whence the charges originated and the amount of each charge, would at once reveal the department responsible therefore and thereby permit the taking of prompt remedial action to prevent its occurrence in the future.

There is illustrated by Form C a statement containing such analysis of late charges for the month of June, 1951. In addition, there is provided on the form sufficient space for showing a summary of late charges by departments.

Analysis of Late Charges
for June, 1951

Name of Patient	Originating Department	Amount of Charge
John Doakes	Laboratory	$ 7.50
Leslie Normal	Pharmacy	1.75
	Total	$45.20

Summary—By Departments

Department	No. of Late Charges	Total
Laboratory	4	15.20
Pharmacy	7	16.25
Total	21	$45.20

Form C

Daily and periodic reports from departments are among the most useful instruments at the command of the administrator both as a means of keeping him informed on the internal affairs of the hospital and in pointing out details to be observed in his routine rounds of the hospital. One such report is the report of personnel utilization and turnover.

From such reports, a summary report for a specific period may be prepared, as shown by Form D wherein a complete record, by department, of personnel turnover is presented. The report shown is for the six month period ended June 30, 1951. Comparisons with similar reports for other six month periods will disclose differences which should be further investigated. Personnel utilization should go hand in hand with utilization of hospital services and facilities. Therefore comparisons of service and facility utilization will indicate whether or not there has been a corresponding increase or decrease in personnel utilization. The frequency with which such comparisons should be made must be left to the judgment of the administrator and his knowledge of the statistical data revealing fluctuations in patient occupancy and hospital service utilization of sufficient proportion to accelerate the rate of employee turnover.

On the Form presented, columns are provided for inserting for each department the number of employees at the beginning and end of the period, the number who resigned or were discharged during the period, the total number who resigned and were discharged and the percentage of turnover. This percentage is computed by dividing the total number of employee resignations and discharges by the total number of employees at the beginning of the period.

Slow Moving Inventory Items

Because of the nature of hospital operations, it is necessary that hundreds of supply items be carried in inventories to provide ample stocks for day to day use. Because of substantial price reductions resulting from quantity purchases, many hospitals find it more economical

Form D

Personnel Turnover

For the six months period ended June 30, 1951

Number of Employees

Department	At Beginning of Period	At End of Period	Resigned During Period	Discharged During Period	Total Resigned & Discharged	Percentage of Turnover
Administration	6	6	2	2	4	66.7
Dietary	14	12	1	1	2	14.3
Total	146	140	21	13	34	23.3

to purchase some supply items in quantities sufficient to take care of their requirements for several months. However, because of spoilage and deterioration, it sometimes happens that certain items cannot be used after 30 days.

It is for the purpose of bringing to the attention of administrators and department heads those items which are either in too great a supply for use in the near future or are perishable and require prompt use before spoilage occurs, that the following form was designed.

Analysis of Slow Moving Inventory Items

June 30, 1951

Description of Item	Quantity on Hand	Quantity Consumed in Past Three Months	Anticipated Period to Exhaust Quantity on Hand	Comments
Surgical Gloves				
—Size 10	20 doz.	2 doz.	30 months	
Elastic Bandages				
3" Wide	98 bandages	18 bandages	16.3 months	

Form E

There is presented by Form E an analysis of slow moving inventory items, showing as of June 30, 1951, a description of each such inventory item, the quantity on hand, the quantity consumed in the past three months, the anticipated period to exhaust the quantity on hand, assuming frequency of use in the future will be the same as in the past, and comments of a specified nature, such as those justifying the condition or indicating what action should be taken to remedy the situation.

It is sometimes thought that indigent in-patients in a hospital are provided with more special services than paying patients. Some are of the opinion that physicians of indigent patients may order certain minor laboratory tests for such patients in cases where they would make these tests themselves for paying patients. This being on the theory, perhaps, that since the doctor may get no pay for his services, the hospital should contribute equally to the care of the indigent.

To determine accurately to what extent indigents are provided special services as compared with those provided to paying patients, a form like that shown by Form F might be prepared. This form provides a ready basis for analyzing the special services rendered to indigent in-patients and for comparing the services and billings with those furnished to paying patients.

The forms may be adapted to the needs of the individual hospital. There are many more special reports which will come to mind, many of which are already in use in a number of hospitals.

Additional Special Reports

To enumerate just a few, the following additional special reports might prove helpful in the administration of hospital operations:

A. Analysis of Consumption of Supplies by Departments
B. Occupancy Rate Comparisons
C. Comparative Food Consumption Report
D. Residence of Patients Report

The accountant and the administrator should discuss the entire reporting picture so that the administrator fully understands what reports are obtainable and the accountant understands what information the administrator wants. Financial reports of a special nature which the administrator may need from time to time should be kept at a minimum. Amendments to special reports should be made as changing conditions warrant. Above all, reports should only be prepared if they are used. It is a waste of time to prepare needless reports or those which administrators consider of little or no value. They should be supplied with those special reports which they understand and use.

Form F

Analysis of Special Services Rendered Indigent In-Patients

June, 1951

	Medical & Surgical Patients			Obstetrical Patients		
	Total Billings*	Number of Patient Days	Billings Per Patient Day	Total Billings*	Number of Patient Days	Billings Per Patient Day
Laboratory						
Paying Patients	$762.60	820	$0.93	xxx	xx	xx
Indigent Patients	272.15	216	1.26	xxx	xx	xxx
X-ray						
Paying Patients	xxx	xx	xx	xxx	xx	xx
Indigent Patients	xxx	xx	xx	xxx	xx	xx
Pharmacy						
Paying Patients	xxx	xx	xx	xxx	xx	xx
Indigent Patients	xxx	xx	xx	xxx	xx	xx

* Based on similar rates for paying and indigent patients

THE Maintenance AND Operations CORNER

By Frank J. Sullivan
Mechanical Engineer, New York City

The Laundry Waste Heat Reclaimer and the Smaller Hospital

Since our discussion of the waste heat reclaimer in last month's TOPICS, I have talked to several administrators who generally were doubtful of its potentialities for hospitals of less than 200 to 300 beds. In checking with laundry equipment manufacturers, I found that on the contrary they believed that the waste heat reclaimer had a place in every institutional laundry.

Further investigation led to a local public utility gas company. This company had only recently tied-into a natural gas distribution pipeline, and was actively pushing the sale of gas fuel for commercial heating of water in an effort to bring their summer and winter loads more closely into balance. Because of tough competition with other fuels and a relative price disadvantage for gas in this location, the utility company was encouraging the installation of heat exchangers to reclaim heat from dishwasher waste water as well as from laundries where gas fuel is used for water heating. One type of reclaimer installation which they found to be most satisfactory was in the neighborhood "Laundry-mat," where they claimed 35 to 45% fuel savings for hot-water generation with the use of the waste heat reclaimer.

Typical 50-Bed Hospital Laundry

As suggested last month, let's work out the theoretical savings which might be possible in a smaller hospital. As a typical example we can choose the 50-bed laundry as shown in the "Elements" of the U. S. Public Health Service.

The pertinent equipment in this layout is as follows:

One Washer—24" x 36"—40 lbs. capacity
One Washer—36" x 36"—110 lbs. capacity
One Tumbler—36" x 18"
One Flat Work Ironer—100"—2-roll
One Press Unit—51"
One Starch Cooker—15 Gallons
One Soap Tank—30 Gallons

For load calculations we will assume the generally accepted factor of 12 lbs. per bed per day. For this size plant the load works out to be 4,200 lbs. per week, or 840 lbs. to be processed during each 8-hour day, with 5-day week operation. (The above equipment was based upon similar load data.) This breakdown for a 5-day, 40-hour weekly operation, rather than a 7-day operation, is often overlooked in laundry calculations. The A.H.A. manual of laundry operation lists only one 36" x 36" washer in its suggested equipment for a 50-bed hospital. This size washer, with a capacity of 110 lbs., would have to operate at maximum capacity through eight washing cycles each day to carry the estimated load. When loading and unloading time is included with the washing formula time, this schedule becomes impractical since the final load from the washer could not be run through the flat work ironer within the 8-hour daily operation. For average operation, calculations should be based upon six maximum-capacity loads each 8-hour day for each washer.

Water Consumption and Waste Water Temperature

To estimate quantities of water used and to determine waste water temperature, we have chosen a generally accepted standard wash-room formula for moderate soil. The water used for each load works out as in figure 1.

In the small washer we will use a total of 328 gallons each load, of which 230 gallons is hot water at 180° F. and 98 is cold water at 55° F. In the larger machine the total is 384 gallons, with 271 hot and 113 cold water.

Allowing a 20° F. drop in water temperature between dumping and use in the heat exchanger, we have available for use for daily operation a total quantity of waste water of 4,270 gallons at a temperature of 125° F. As noted above, we will require (230 + 271) × 6 or 3,006 gallons of 180° F. hot water for the six loads in each machine. This means that we can use the 4,270 gallons of 125° F. waste

Figure 1

Operation	Water Level	24" x 36" Washer — Gallons & Temperature (°F.)					36" x 36" Washer — Gallons & Temperature (°F.)				
		100	120	140	160	180	100	120	140	160	180
1. Suds	6"		37					56			
2. Suds	5"					22					26
3. Suds & Bleach	5"				22					26	
4. Rinse	12"				45					50	
5. Rinse	12"					45					50
6. Rinse	12"				45					50	
7. Rinse	12"			45					50		
8. Blue	12"	45					50				
9. Sour	5"	22					26				
Total Water		67	37	45	112	67	76	56	50	126	76
Hot (@ 180°F.)		24.2	19.2	25.5	94	67	27.4	28.1	34	105	76
Cold (@ 55°F.)		42.8	17.8	19.5	18	0	48.6	27.9	16	21	0

water to heat the 3,006 gallons of cold water from 55° F. to whatever temperature is possible in the heat exchanger before it goes to the hot water generator.

To determine the cold water temperature leaving the heat exchanger, we will assume a final temperature for the waste water of 100° F.—that is, we assume that the heat exchanger was able to reduce its temperature by 25° F.

$4{,}270 \times 8.3 \times 25 = 3{,}006 \times 8.3 \times$ T.D. Solving for T.D. or the temperature difference of the cold water leaving the exchanger, we get 35.5° F. Assuming an over-all efficiency of 90% for the exchanger (which is not too high for a properly designed shell & tube exchanger), we get $35.5 \times 90\% = 32°$ F. rise or a final temperature of 87° F. This 32° F. rise in temperature represents approximately 100,000 Btu per hour (on an 8-hour basis), or approximately 3 boiler horsepower, which is the equivalent of a 20% fuel saving for the entire laundry operation.

Further Refinement Means Greater Savings

As you will remember from our discussion last month, the average smaller hospital's heating plant is not equipped to operate at best efficiency and much valuable condensate and flash steam is wasted. Where proper equipment is not installed to fully utilize the available heat units in high-pressure condensate, the condensate from the laundry equipment can be efficiently used in the heat exchange apparatus shown in Figure 2 of last month's issue.

Published data on steam consumption for this size laundry averages at about 325 lbs. per hour neglecting steam for hot water generation. Since we will assume that our heat exchange apparatus will raise our water to a temperature of 120° F., we will still need steam to raise it to 180° F.

$24{,}950 \times 60 = 1{,}497{,}000$ Btu
or approximately 1,500 lbs. steam
or approximately 188 lbs. steam per hour will be required.
$188 + 325 = 513$ lbs. per hour consumed.
Note: Capacity of the hot water storage tanks has been eliminated from the discussion, which naturally raises our hourly consumption on an 8-hour basis.

Since we consume 513 lbs. of steam per hour (all assumed at 100 p.s.i.), we will have 513 lbs. of condensate per hour to put into our exchanger. Since our system is vented and equipped with a vapor condensor, we will drop the temperature of the condensate from about 306° F. to 180° F. to obtain a net available heat of 126 Btu per pound or a total of 65,000 Btu per hour. Again using on aver-all efficiency of 90%, we will have a net transfer of 58,500 Btu per hour. Since our hot water consumption is 24,950 lbs., or 3120 lbs. per hour, we can expect an increase in temperature through the second and third stages of the heat exchange apparatus of approximately 18.5° F.

Total Gain Through the 3-Stage Exchanger

The total heat rise of the cold water in its passage through the complete waste-water and condensate heat exchange apparatus is estimated to be 50.5° F., with a final temperature of 105.5° F.

This total heat gain for the required hot water represents approximately 5.2 boiler horsepower or a saving of roughly one-third of the total laundry fuel consumption.

Care And Maintenance ASPHALT FLOORS

By Dave E. Smalley, Floor Consultant

ALTHOUGH asphalt is still less expensive than other popular floors, it is no longer chosen only on the basis of price. It has the advantage of adaptability for almost all conditions, and it can be installed on almost any type of sub-floor which is sufficiently smooth to prevent the somewhat brittle tile from breaking under a strain. Of all floor coverings it is the best adapted for use on concrete, being almost immune to its natural alkali. It is the most abuse-proof, and yet it has features even more vulnerable than those of other coverings.

For example, oils, napthas, turpentine and gasoline quickly dissolve asphalt, and except for the special grease-proof asphalt designed for kitchens, greases of any kind are damaging. On the other hand, it is not affected by alcohol, ether and most other chemicals commonly used in hospitals.

But asphalt tile shows neglect and improper or inadequate maintenance sooner than most other types of flooring. Clear water mopping for example, which is usually effective on terrazzo, linoleum, ceramic and rubber tile often tends to dull asphalt unless it is waxed.

All of the special asphalt problems are readily solved if these proper methods are followed:

First, the exact nature of asphalt tile must be understood. Usually made of asbestos fibers, mineral pigments, asphaltic and resinous binders, it is supplied with flexibility and great toughness, but is not nearly as pliable or resilient as rubber and linoleum. Unless it is very warm, it will break before it bends. It is not uncommon to see broken asphalt tile due to some severe shock or an uneven place in the sub-floor, but it is easily replaced.

Sharp objects allowed to stand on asphalt tile, especially under weight, are likely to make permanent indentations. Since the beds in most hospitals are provided with soft-tread casters, no damage is suffered from them, but care should be taken with other furniture less protectively equipped.

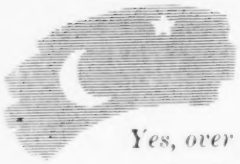
Guard Against Excessive Heat

Asphalt tile should also be guarded against excessive heat. It is not inflammable but will soften at high temperatures. Never lay hot objects on an asphalt floor.

To clean an asphalt floor effectively use mild alkalies or soap slightly on the alkaline side. Neutral soaps are sometimes "too neutral", leaning to the fatty side which is detrimental to the tile.

However, this becomes less important with the advent of the new "soapless" cleaners. These synthetic cleaners, which resemble liquid soap are new developments of sulphonated alcohol or sulphonated hydrocarbons, and besides being excellent emulsifiers they are powerful wetting agents, giving them a capacity for penetration impossible with soap. They are harmless on any kind of washable surfaces and should be excellent for asphalt.

(Continued on next page)



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A Good Floor Wax Is Needed

To keep an asphalt floor looking its best, a good floor water wax is needed. It is seldom necessary to mop a well waxed floor unless something is spilled. This should not dull the finish. If it does, the gloss can be restored quickly by buffing.

In applying a water wax to a new asphalt floor, the wax may have a tendency to crawl, and if allowed to dry it makes a spotty, unsatisfactory finish. This is due to excessive surface tension, the result of a water-resisting surface film often found on new asphalt and linoleum. To prevent this, the new floor should be first cleaned with a recommended cleanser.

Faulty wax film can rarely be buffed out satisfactorily, so it is better to remove it and wax the floor again.

If two coats of water wax are to be put on, always be sure the first coat is dry before the second is applied. Allow from two to six hours, depending upon weather conditions. Polishing hastens the drying.

Excess Wax Shows Up White

The wax may turn white on an asphalt floor. Asphalt tile occasionally has a pitted surface, and an excess of water wax settles in these pits and remains white or gray. Because the tiny pockets of wax are below the sweep of the polish brush, they cannot be buffed out. Good self-polishing waxes, usually dry transparent even in the pits, but occasionally in a faulty wax, some will remain white in the small but dense accumulations. This can be remedied by scrubbing with soap suds.

Varnish, regular floor sealers, and lacquers should never be used on asphalt tile as they wear off unevenly.

Concluding that only water waxes are suitable for maintaining asphalt floors, the major problem is slipperiness. This is caused by asphalt's natural hardness and smoothness.

It is possible the wax may be improperly applied—not rubbed out as it should be. The wax may not be entirely dry due to poor drying conditions or application over a damp floor.

Instead of throwing out the wax, try going over the floor with steel wool (about No. 2 grade), and applying another thin coat of wax.

The United States Bureau of Standards and the Underwriters' Laboratories found that two coats of wax are less slippery than one. It is better to apply the coats thinly, preferably with 12% wax. The first coat must be dry before you apply the second, or you may have the equivalent of one heavy coat. In extreme cases it is sometimes necessary to dilute even a 12% wax as much as 50% with water and apply two or three coats. Buff each coat when dry.

Recently a new non-slip element has been added to some floor waxes which seem to be safer than regular waxes. Floor waxes are most likely to be slippery, however, before they are fully seasoned.

Safeguard Against Slipperiness

Another safeguard against slipperiness is to keep the floor free from dust, sand, litter, etc., which increases the slip hazard materially. These loose particles act like roller bearings under the shoe sole. Avoid such accumulations, especially near entrances and corners, in front of elevators and where people stop or turn quickly.

In trying to meet the slip hazard on asphalt tile do not resort to the resin-loaded waxes which become sticky, hold dirt and resist mopping, dusting and buffing. No wax at all is better than a gummy mess that eliminates one problem to create another.

Waxes which have been tested and approved by the Rubber Manufacturers' Association for quality and by the Underwriters' Laboratories for safety are your best and safest bet. There are a number of such available.

If you are still afraid of wax on asphalt tile, and there are certain places where waxing might make the floor hazardous, go over the dry floor at regular intervals with fine steel wool under a floor machine. This method gives the asphalt a satin-like sheen which avoids the dull effect left by wet mopping. Most of the asphalt tile manufacturers approve this form of cleaning, but the revolving steel wool should not be held too long in one place or the heat will tend to melt the asphalt.

If You Must Scrub Asphalt

If you feel you must scrub your asphalt, avoid strong cleaning solutions and too much water. While the asphalt itself is almost immune to such solutions, they may seep down between and under the tiles, causing them to loosen from the sub-floor.

Asphalt tile is one of the most durable of floors and one of the most resistant to abuse, but like everything else, is serves best and longest when it is properly cared for.

Look for previous articles which have appeared on the care and maintenance of terrazzo and rubber floors.

An APPROACH to HUMAN RELATIONS

By David H. Dingilian

Part II—Dependence to Independence

Introduction

In our previous section we asked the question, "How Grown-Up Are We?" In attempting to answer the question we outlined a brief statement of the criterion of maturity as an index. We listed certain characteristics which portrayed mature behavior.

In this second brief we shall touch upon the process of moving from a complete state of dependence upon others toward eventual independence and adulthood in its truest sense. The basic discipline from which we shall draw our data is the science of psychodynamics.

Psychodynamics

There is a rapidly growing new science called psychodynamics. Please do not be afraid of this word. It will play an important part in the human affairs of tomorrow. This science deals with the forces of the mind. It studies the ideas and impulses which are charged with emotions and which express themselves in terms of psychic energy. In the life of each of us various types of behavior are manifested at every turn. One cannot ignore behavior which has psychological significance any more than one can ignore those aspects of behavior which manifest themselves socially or physiologically. The important point here is that we are relatively more familiar with sociology and physiology than we are with those aspects of the individual's behavior falling both in the general area called psychology as well as the specific area called psychodynamics.

Psychodynamics, then, deals with the organization of man's internal private world. It tries to understand the single uniqueness as it is manifested in the behavior of each individual. It gives us clues to behavior which we can call "adequate" or "inadequate," "mature" or "immature," or in simple everyday language, it helps us to make appraisals as to whether or not the individual is grown-up and if so, the extent to which he is grown-up. The significance of this new field for parents, teachers and school people in general is obvious and needs no elaboration.

We have given the above brief sketch of this new science in order to lay the setting out of which has come the knowledge which we are about to describe—the process of gaining independence and achieving adulthood.

The First Few Years

It is this writer's opinion that the importance of the early years has been stressed, written about, and discussed but internally felt by too few workers in the field of human relations. Unless we *feel* truths and incorporate them into our everyday ways of living, they become mere intellectual impediments. Idealistic subjects are a good example. We can talk UNESCO and sincerely get stirred up about it. But unless we are able to instrument specific ways of behaving in our everyday interpersonal or interprofessional relationships which add up to the grand and potent ideals of UNESCO, we have not accomplished much.

In this same sense we feel strongly about the need for parents, teachers, and all workers in the area of human relations to feel, accept .and interiorize the facts of the importance of the early years. It is important that we carry on our work from such an orientation.

The starting place for us in this regard is the dramatic contrast between the totally parasitic state of the newly conceived child and the wonderfully complex organism exemplified in the full-grown, reasonably adjusted and efficient adult.

The first has to have its basic needs of warmth, protection, nutrition and respiration furnished to it by the parent organism. In a sense, the intra-uterine environment is the only perfect environment in existence. The organism, once born, will never again have such a state of Utopia as his field for interaction, operation and survival. The mother, carrying her child, furnishes for him the most equilibrized and juxtaposed setting.

This very brief reference to the prenatal environment of the human organism is such a contrast to the numerous, constant and ever-threatening nature of the forces operating in the post-natal environment that we shall not have to say much about the latter. Each of us is the product of his own biography and can easily understand what is meant by the phrase, "the impact of the environment on personality." One out of every twenty Americans is actually suffering from some form of emotional stress as a result of such an impact.

What should we keep in mind as being salient points about these early years?

1. The child comes into this world with the capacity to use every structure within his organism for the purpose for which it was designed.

The ability to move his eyelids, legs, arms and tongue; the capacity to cough, sneeze and breathe; the impulse to suckle, swallow and digest; the ability to see, feel, cry and hear—all these were given a good start in the nurture and organization which took place "in utero" during the prenatal period.

2. Even though the child inherits the structure described in the above paragraph, he still must *learn* to use this structure.

Learning during these early years is that process whereby the youngster comes to develop a somewhat satisfactory pattern of managing his bodily tensions. This involves constant interaction with the immediate environment. The family's role in this interaction process is the key to the youngster's proper socialization. If it is a warm, loving, and secure family, then the child already has internalized the basic prerequisites for future independence. The edifice which he builds will have all the characteristics of his family. These may be good and stable characteristics or they may be neurotic, insecure, hostile and aggressive. The first set of family patterns lead to independence and adulthood; the second keep him dependent and fixated to the use of infantile ways of coping with life's confrontations.

The Basic Role of the School

The key role of the school in helping the youngster to continue his forward move toward independence is found in the concept: Do not underestimate the youngster's intellectual capacities nor overestimate his powers of emotional control.

If we parents and educators can but know ourselves sufficiently as to permit us to go beyond our own immediate needs to those of the youngsters, then the basic step toward helping children toward independence will have been taken.

The child takes the learned behavior of the home to school. However, he now has the problem of continuing to eat, wash, eliminate and dress in the midst of an ex-

panded environment containing the loves, rivalries, rebellions and self-assertions of a host of strangers. The school becomes the family magnified. It is the place where intellectual and emotional adventures may be had with persons, things, events and dreams. There is no reason why it cannot be a place where "joyous achievement" is the menu for each day.

This means that, like the family, the school must be warm; the personnel must be outgoing as well as loving; and learning activities must be stimulating rather than humiliating or threatening. If such is the case, the edifice of independence started by the child in the home will continue to grow toward greater independence in the school. However, if the school is not a happy place, such syndromes as tics develop; latent hostilities and aggressions, rather than finding outlet, may either be repressed or allowed to run rampant and the youngsters may come to feel that they are but the prisoners of the law.

Some Generalizations

Space does not permit even a summary discussion of the details of the stages involved beyond the early years which the child must experience on his journey toward independence. Our literature is replete with clinical information about the "latency period" or "the onset of puberty and adolescence." Constant study of the latest in such data, by teachers and parents, is a must.

We can, however, keep in mind the following points:

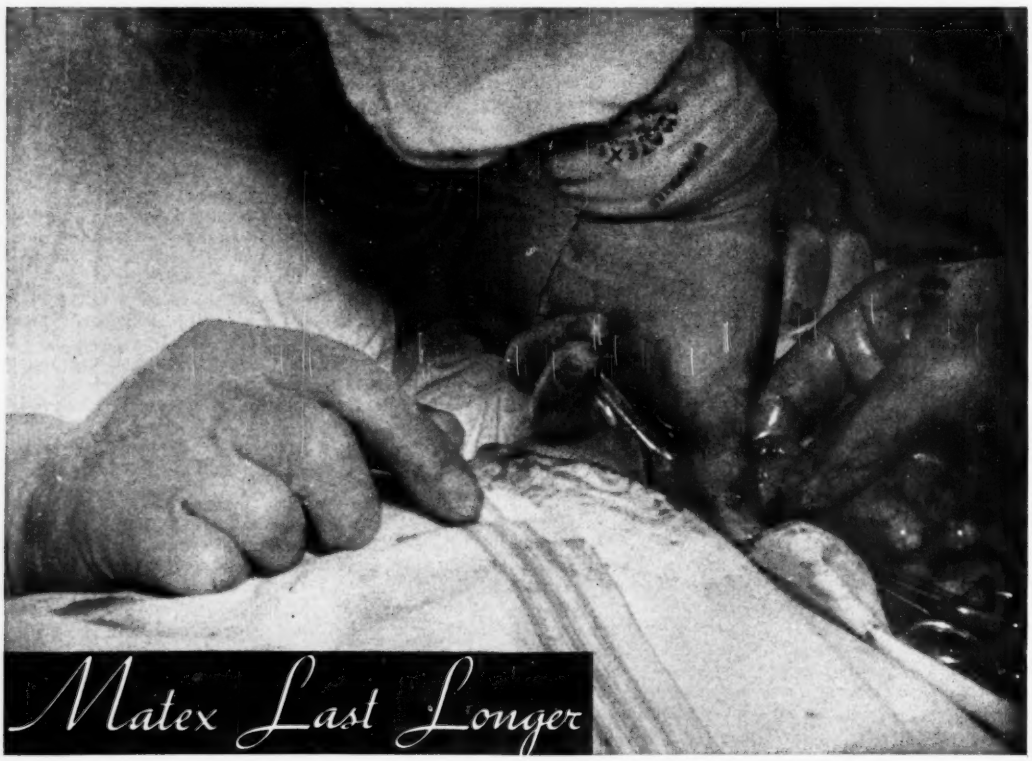
1. The biological process of the youngster's development, in its inter-action with the social environment, *can* be directed toward greater and greater independence. This is better achieved if we add to our present knowledge of the physiological sciences the latest clinical insights now accumulating in a new science called psychodynamics.

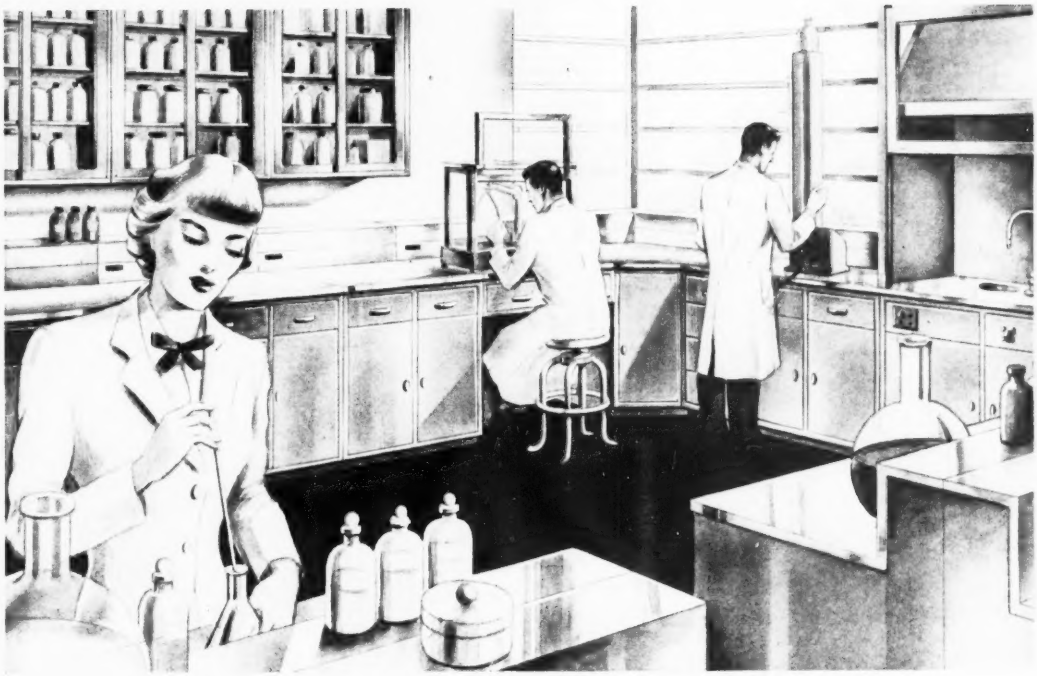
2. The so-called "lower" species are controlled more rigidly by what, for the lack of a better word, are generally referred to as "instincts." In contrast, man belonging to a "higher" species, is modifiable and more subject to the manipulations of his immediate environment and culture.

3. The young child's development proceeds "unevenly and irregularly." This means that the home, the school and other institutions must always remain *means* and never become *ends*. They must serve and facilitate development rather than superimpose.

4. The proper *timing* of our methods in helping youngsters to move toward independence is a very important factor. Timing is important because each personality has within it the ever-present temptation to withdraw and regress to earlier, more infantile modes of coping with his immediate problems. This is the ever-present threat and danger to the goal of achieving independence.

5. If the youngster is (a) basically loved and made to feel secure by parents and teachers; (b) allowed to develop with the bare minimum of interference; and (c) has well-balanced teachers and parents as models, he will achieve a reasonably adequate degree of independence. He will in turn become a more mature parent, possibly teacher, and contribute materially toward the breaking up of the most insidious disease of our times; namely, neurosis. He will achieve wholeness. One of the most important questions asked by Jesus in his teachings was, "Wilt thou be made whole?" To achieve wholeness is to achieve independence.





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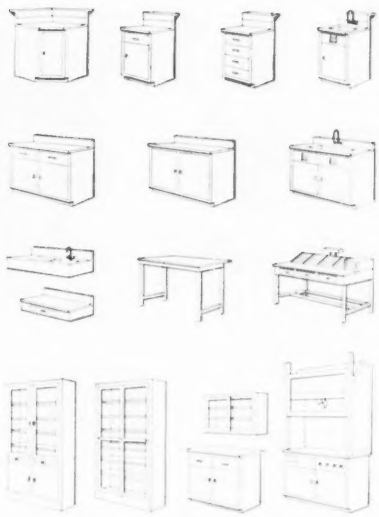

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THE LAB

A regular feature for Medical Technologists

Simple Test in Pancreatic Disease

In the Oct. '51, *Review of Gastroenterology*, McGavack of New York, says that it is of practical importance to mention the usefulness of the single-specimen liver function test for those people upon whom surgery is to be done. If the esterification of cholesterol is not good, and the albumin-globulin ratio is disturbed, postoperative digestive problems will be great.

Table 1

Behavior of Serum Amylase, Lipase and Alkaline Phosphatase In Patients with Pancreatic Disease.

Pancreatic Condition	Serum Amylase	Lipase	Alkaline Phosphatase	Mecholyl Response
Acute Inflammation	Elevated	Elevated	Usually Normal	Contra-indicated
Chronic Inflammation	Low to Normal	Low to Normal	Usually Normal	Little or No Response
Nutritional Diseases	Usually Low	Usually Low	Normal	Satisfactory Response
Obstructive Lesions	Variable Low to High	Variable Low to High	Usually High	Usually Normal

In addition to the single-specimen tests for liver function, the author feels the following are useful and within the scope of every hospital laboratory: serum amylase, lipase, alkaline phosphatase, and lipase after the intramuscular administration of mecholyl. The mecholyl procedure involves the giving of between ten and twenty milligrams and following the changes which occur in serum lipase at zero, fifteen, thirty, sixty, and ninety minutes. Usually the maximum increase appears at about thirty minutes.

This test is not of value if negative, but, if positive, that is if there is a distinct elevation, it is certainly of confirmatory value.

In the diagnosis of the acute inflammatory lesions of the pancreas, serum amylase has been looked upon as one of the best tests. While it rises rapidly, it falls quickly to normal often within forty-eight to seventy-two hours. On the other hand the serum lipase, while also elevated early, remains high for a considerable length of time. These laboratory tests are our best for confirming the presence of acute pancreatic edema, and hemorrhagic pancreatitis with or without suppuration.

Alkaline phosphatase will be of use in excluding an associated disturbance in the hepatobiliary tract. Occasionally this may be elevated in cases of acute pancreatitis with edema about the ampullary region.

Microfluorometric Scanner

The development of a microfluorometric scanner for the automatic searching and detection of cancer cells in preparation of exfoliated cells appears to be feasible according to Mel-

Normal Human Plasma, dried for stability. No preservative added but treated with ultra-violet radiation. Each 100 cc. contains approximately 660 mg. of gamma globulin and is the osmotic equivalent of 200 cc. of whole blood. Available in 50, 250 and 500 cc. units with diluent and double-ended needle for restoration. Quickly restored to isotonic or hypertonic concentration—easily administered.

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lors and Silver, New York, in *Science*, Oct. 5. This instrument, it is hoped, will serve as an adjunct to the Papanicolaou technic in the screening of the population for certain types of neoplastic diseases. With modifications in technical and staining protocol to be described elsewhere, such an instrument has potential application in clinical hematology, for the differential counting of cells of the peripheral blood and the bone marrow.

The Thorn Test During Cortisone Therapy

Technic used by Krebs and Holmes, Rocky Mountain Medical Journal, January, 1952.

The Thorn test used by the authors was similar to that originally described by Thorn, including the same counting technic. In the early studies no food was given during the test; later the procedure was modified to include a light breakfast (toast and coffee or milk), which apparently did not affect the results of the test. After collection of the control specimen, adrenalin was administered subcutaneously (0.3 c.c. of 1:1000 dilution).

Blood samples were taken at one and four hours after adrenalin administration. In later cases the one-hour blood sample was omitted because in most instances it had shown no more than a minimal drop in total circulating eosinophil count. The results of the four-hour specimen are, therefore, used throughout this report.

Control tests were performed prior to receiving Cortisone therapy, and repeated at weekly intervals during Cortisone therapy. The initial dose of Cortisone varied from 150 to 300 mgm. per day. After the first week it was reduced to 50 to 100 mgm. per day.

In this series the course of therapy lasted from three to eleven weeks, and the total dose varied from 2.3 to 10.0 gms. The study involved thirty-eight patients and approximately 160 Thorn tests.

In the average data on the twenty-six cases presented, the total circulating eosinophils showed a definite drop during the first two weeks of therapy and a return to normal during the third and fourth weeks of treatment.

The Thorn test frequently improved during the first two weeks of therapy, but during the third and fourth weeks was frequently much less than the control. The test has proved disappointing as an aid in the management of these cases.

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Medical Technologist Listed on Radiological Exhibit

The name of a medical technologist, Ellen Skirmont, was listed as a participant in a scientific exhibit which won a certificate of merit at the recent Radiological Society of North American meeting in Chicago. The exhibit, "Radium Toxicity", described a project undertaken by the Argonne National Laboratories under direction of Dr. Robert J. Hasterlik and Leonidas D. Marinelli. Miss Skirmont is a member of the program and public relations committee of ASMT.

St. Louis Chapter of ADT Organized

The newly formed St. Louis University chapter of Alpha Delta Theta, National Professional Sorority of Medical Technologists, has elected and installed officers.

Mary Jo Allhoff was elected president; Jean Butzen, vice president; Kit Bragg, secretary; and Yolanda Boveri, treasurer.

Charter members of the new organization, in addition to the officers include Irene Schulze, Stephanie Shega and Therese Stuesse.

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Ward Rounds of the Future?

A complete revision in the procedure of ward rounds may not be in the too distant future when the back-pack television camera and transmitter, previewed at the AAAS meeting in Philadelphia, comes into common usage. The camera, developed by RCA is demonstrated at the right by Dr. R. K. Marshall, noted commentator.

Photo Courtesy R.C.A.

Important Teaching Device

The portable television camera needs no ampitheater; can pick up technic in a small room, such as a cast room (above), or can be used to teach nursing procedures at the bedside (right). For large audiences (below) several receiving sets may be used.

Photos courtesy Smith, Kline and French

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Castle **STERILIZERS AND LIGHTS**

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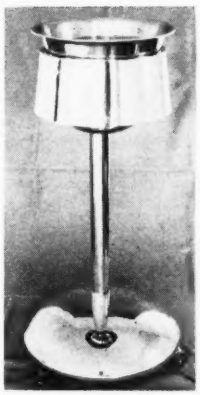
546. New Sterile Solution Warmer for Improved Operating Room Efficiency. Approved by Underwriters' Laboratories. Unit is explosion-proof in gases used in operating rooms. Equipped with Faultless conductive rubber casters eliminating hazards of explosion by static electricity sparks. Unit includes heating stand, metal drape and standard Vollrath seven-quart basin. Fully guaranteed for one year against defective workmanship and material. Medical Instruments & Equipment Co.



655. Spark-Proof Coating for Floors to make them conductive of electricity. Conducote, plastic-like composition reported to be effective on every floor excepting rubber and asphalt. Thinned to free-flowing consistency and painted or troweled over entire floor area. The manufacturers recommend that not less than four coats be applied. Dries to smooth, even finish, easily maintained. Available in red, green, brown, black or grey. UL and Electrical Testing Laboratories approved. Walter C. Legge Co., Inc.

193. K-S Disposable Oxygen Mask for exceptional efficiency, comfort, sanitation and compactness. Clear, lightweight, soft-textured plastic with heat-sealed seams which assure efficient operation. Pliable metal "conforming strip" holds mask securely to contour of face and nose without undue pressure, gaps or wrinkles, and reduces oxygen escape to minimum. Light elastic band comfortably holds mask under chin. Worn by one patient, then discarded, thus eliminating danger of cross infection and need for costly and time-consuming sterilization. Ohio Chemical & Surgical Equipment Co.

656. New Filing Method, called Kard-a-Film, permits creation of active files by subject, name or number using microfilm as filing instrument. Combines space-savings of microfilm and reference benefits of paper record filing, meets need for faster, more accurate record reference. Remington Rand Inc.

657. Maternity and Nursing Bra for effective, comfortable support during pregnancy and later as a nursing brassiere. Adjustable straps remain comfortably on shoulders at all times. Front section of cup drops down for modest, easy nursing. Shaped elastic insert in diaphragm. When worn as a nursing bra, protection is guaranteed by simply inserting the Anne Alt Disposable Pad . . . moisture proof, sanitary. Anne Alt Brassiere Co.

658. Convenient "Do's and Don't's for Safety" Card, featuring recommended safety practices with gases and equipment. Attractive, easy-to-read, presents separate listings of safety suggestions for use of oxygen and nitrous oxide, laboratory gases, flammable gases and vapors, as well as for the operation of anesthesia apparatus, sterilizers, and oxygen tents. Reverse side lists "Important Factors in Sterilization," "Properties of Medical Gases," and an "Hours of Service" table for oxygen cylinders. Ohio Chemical & Surgical Equipment Co.

471. Pillow Radio With "Controlled Volume." New model incorporates all desired features expressed by administrators and hospital staff. Available to hospitals free to those who qualify. The Dahlberg Co.

518. Syring-O-Pak, New Technic for Preparation and Sterilization of Syringes by autoclaving process. Sterility maintained indefinitely in storage or until syringe is removed from Pak. Permits rapid packaging of individual syringes and needles. Eliminates wetting of syringes before and assures dry syringes after sterilization. Does away with cloth wrappers, metal or glass containers. Reduces handling, breakage and equipment costs.

660. Wallich Baby Identification System. No inks or oily stamp pads necessary. Identification markings can be done with ordinary lead pencil. Fingerprints made using Wallich "Marking Cake." Band with marking is oil-proof, tamper-proof, water-proof, and when in place, fits free

(Continued on next page)

as a bracelet, yet can be removed only by cutting apart. Band is no thicker than tape—can be sealed to hospital records for permanent filing and future microfilming. Non-irritating. Non-allergic.

661. An Advanced Technic for Colloid Baths, Aveeno, new concentrate from oatmeal, ready for instant use. Provides prolonged emolient action on irritated skin areas . . . controls pruritus ani and pruritus vulvae . . . relieves itching and skin irritation in general rashes, sulfa and penicillin rashes, eczemas and allergic reactions. Helps prevent spread of infection by relieving itching, thus promoting a more rapid return of natural healing processes.

662. Mary-Jane, the Original All Elastic, Light-Weight Garter Belt. No bulge, no bind, no bother, yet hose stay smooth, seams straight without strain, drag or pressure. No back garters to sit on. Recommended for mothers-to-be because there is no strain or pressure on the abdomen. Completely adjustable . . . one size fits any figure.

663. New Storage Cabinet for Radioactive Samples. Provides for replacement of sample holders or the sample holding tray in case of contamination. Sample holders are plastic cups which are pressed into holes in tray. If contamination occurs, these cups are easily replaced at little cost to user. Nuclear Instrument & Chemical Corporation.

664. Pneumatic Tourniquet made in such a way that an even pressure can be applied over a large area and exact amount of pressure can be determined, providing a means of preventing tourniquet paralysis. Easily applied and may be deflated at any time without disturbing operator or sterile surgical drape. Richards Manufacturing Co.

665. "Vapor-All" vaporizer inhalator now equipped with automatic electric cut-off. Scientifically designed for treatment of respiratory ailments. Vapors start quickly—no salt needed—no spurting. When vaporizer boils dry, current cuts off automatically until water is replenished and thermostat reset. Hospital tested and proved for trouble-free efficiency. Sanit-All Products Corp.

337. Waterless Hair Bath a boon for sick-a-beds. Easy to use. Liquid applied directly to hair from shaker top of bottle. Dirt and liquids are removed together when head is rubbed gently with a turkish towel. Two applications for best results—the first loosens and dissolves dirt, the second removes film and conditions the hair. Hospital Beauty Service, Inc.

532. Orthopedic Equipment Company announces development of the baked on ALU-METAL process. All pressed aluminum splints are finished by this process which is a non-toxic and x-ray translucent covering. Process permits bending to shape, rough handling, sterilization or washing with soap and water of splints without affecting finish. Can be stored indefinitely without oxidation occurring, avoiding transfer of black oxidized surface to patient or surgeon. Profusely illustrated three-colored catalog.

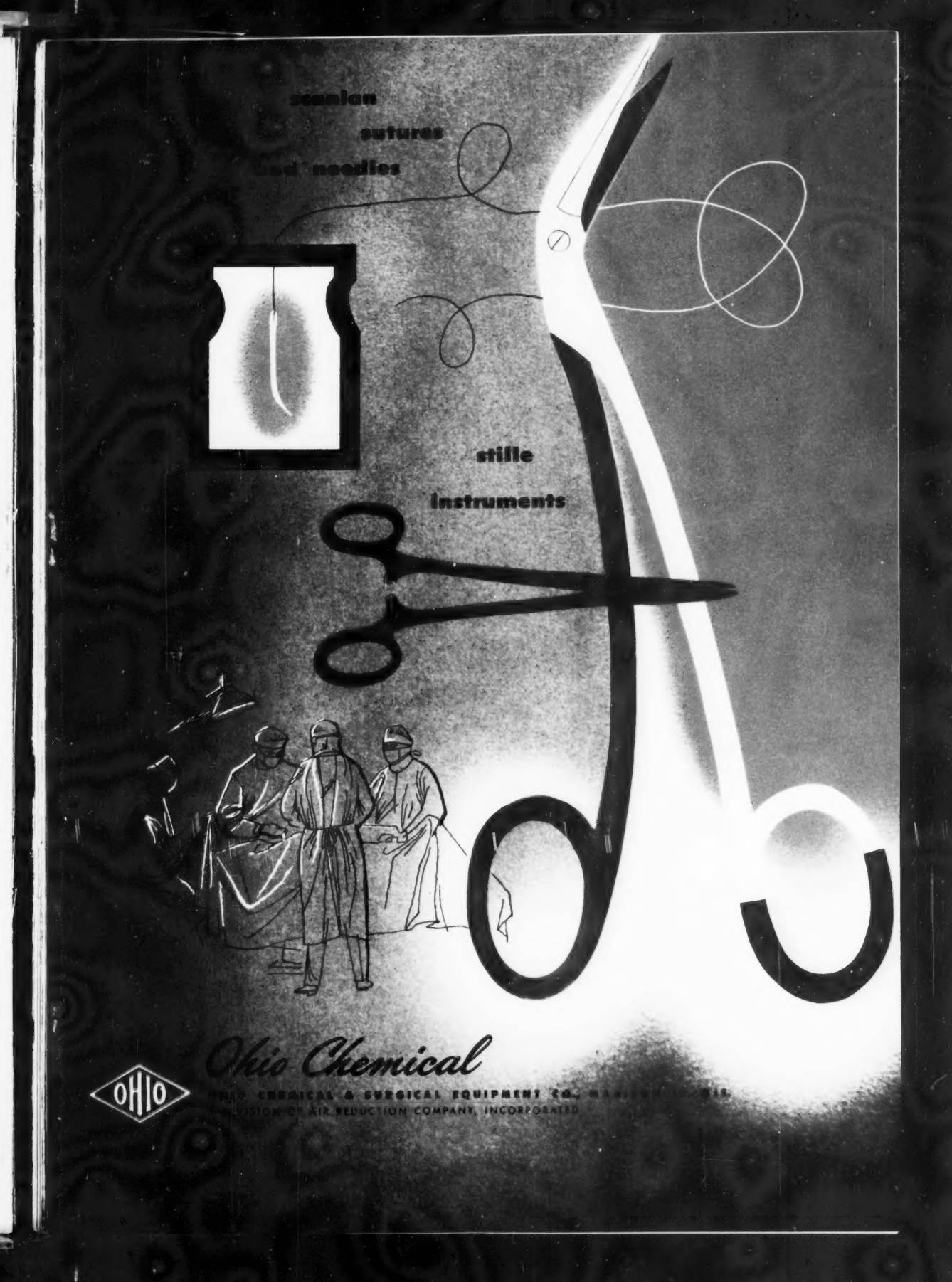
666. Formica Top on New Model 832 Dresser-Desk to combine beauty with durability and low maintenance cost. Material is unharmed by alcohol, fruit acids, medications and even boiling water. Finish illustrated is frost walnut. Company's line also includes chest, dresser, bedside cabinet. Hospital Furniture, Inc.

543. Liquid Detergent Cuts Floor Cleaning Time in Half. Eliminates rinsing. Restores original luster and beauty to asphalt and rubber tile floors. Equally effective and efficient on terrazzo, linoleum, cork, mastic and wood. Quickly and easily cleans woodwork, furniture, beds, and walls as well as floors. Ideal for fast, thorough clean-up of rooms and wards before occupation by new patients. J. F. Kerns Co.

667. New Anti-Fog Liquid Prevents Fog, Mist and Steam, when applied to any glass or plastic. Forms an invisible protective film which keeps surface fog-free for indefinite periods. Assures perfect vision in any weather, temperature or climate. Non-toxic, non-acid, non-inflammable. Easily applied with soft cloth. Solution keeps indefinitely. Removes any form of dust, dirt, grease or fingerprints easily without harm to glass or softest plastic. Merix Chemical Co.

671. Dry Ice Apparatus for Cryotherapy. Skin lesions are removed by Cryotherapy with a minimum of discomfort to patient and with cosmetically superior end result. 70°C temperature of dry ice causes prompt anesthesia in affected tissue. No local anesthetic is required. Therapy easily controlled by varying pressure and time of application. Kidde applicators confine dry ice to lesion. Healthy tissue cannot be damaged by fragments. Kidde Mfg. Co.

670. Fibredown Underpads provide greater patient comfort and convenience by virtue of their capacity to absorb fluids instantly . . . in large volume. Unexcelled for bedding protection and allied hospital uses. Anchored with water-repellent glue at 5 strategic points as a provision against collapse of wadding when handling as well as overlapping or bunching due to patient posture changes. Fibredown processing feature means less irritation for patient, greater service durability, conservation of valuable nursing time. Sample available. General Cellulose Co., Inc.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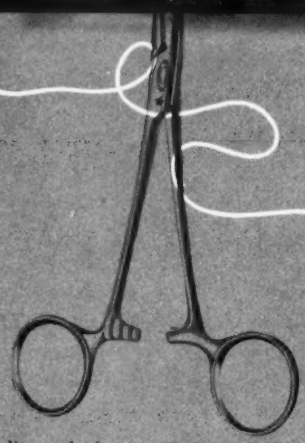

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Warranted sterile. Only select suture materials are used, tested for uniformity of strength, flexibility, and absorption. A variety of types, with and without special needles attached. Ask for Catalog No. 2074.

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Here are a few items described elsewhere in this issue you may want to request when sending for other information on the postage-paid card at the right.

Special Offers

Manufacturers of Foille offer samples and clinical data on the product.

If you send a rough sketch of room, indicating beds, Capital Cubicle manufacturers will submit plans, specifications and cost for cubicle curtains with no obligation.

Winthrop Stearns offers a free pad of diet sheets.

O.R. Supervisors

Gudebrod offers you a new leaflet on Non-Absorbable Sutures to keep in your files.

Steam-Clox manufacturers will send a complete sterilization file on request.

Send for additional information on the following:

- Nightingale Brochure
- Gomco General Catolog
- Incubators
- Laboratory Equipment
- Operating Tables
- Cartrids
- Emetrol
- Surgical Lights
- Wheel Stretcher
- Pillow Radio
- Safe-T-Aire Lamps
- Leg Exerciser
- Haemo-Sol
- Glovemaster
- Dar-Kol Surgical Instrument Oil
- Luxor Alpine Lamp
- Elastikon Tape
- Amp-O-Vac
- Orthopedic Crutches

Send more information on items checked.

- ☐ 28 Neva-Lose Scissors
- ☐ 337 Waterless Hair Bath
- ☐ 471 Dahlberg Radio
- ☐ 493 KS Oxygen Mask
- ☐ 509 Faultless Casters
- ☐ 518 Syring-O-Pak
- ☐ 532 Aluminum Splints
- ☐ 543 Floor Detergent
- ☐ 546 Solution Warmer
- ☐ 572 Vaseline Dressings
- ☐ 595 United Wire Mash
- ☐ 703 Hausted Stretcher
- ☐ 655 Conducote
- ☐ 656 Kard-a-Film
- ☐ 657 Anne Alt Bra
- ☐ 658 Do & Don't Card
- ☐ 660 Wallich Baby Band
- ☐ 661 Aveeno Band
- ☐ 662 Mary Jane
- ☐ 663 Storage Cabinet
- ☐ 664 Pneumatic Tourniquet
- ☐ 665 Vapor-All
- ☐ 666 Dresser-Desk
- ☐ 667 Anti-Fog Liquid
- ☐ 669 Elastic Adhesive Tape
- ☐ 670 Fibredown Underpads
- ☐ 671 Kidde Dry Ice
- ☐ 672 Life Size TV
- ☐ 673 Fluoradex
- ☐ 674 Speciment Diaper
- ☐ 675 Pathocide
- ☐ 676 Davidson Incubator
- ☐ 677 Hearing Aid
- ☐ 678 Rubberized Paint
- ☐ 679 Modocoll
- ☐ 680 Diluting Pipettes
- ☐ 681 Call-Button Holder
- ☐ 682 Shower Stall Base
- ☐ 683 Kodak X-Ray Hangers
- ☐ 684 Arrow Commode Chair
- ☐ 685 Cafecofe
- ☐ 686 Weck Prep Razor
- ☐ 687 Derma-Fresh
- ☐ 691 Ether Squibb
- ☐ 692 Sodasorb
- ☐ 693 Miss Curity
- ☐ 694 Sandoz Atlas
- ☐ 695 Therapeutic Nutrition
- ☐ 696 Hospital Equipment
- ☐ 697 Protective Equipment
- ☐ 698 Protective Paints
- ☐ 699 Freeman Supports
- ☐ 700 Continental Stat Sets
- ☐ 701 Noise Elimination
- ☐ 702 Baby Feeding
- ☐ 703 Uterine Canver
- ☐ 704 Trick Roping
- ☐ 705 Columbia Films

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Send more information on items checked.

- ☐ 28 Neva-Lose Scissors
- ☐ 337 Waterless Hair Bath
- ☐ 471 Dahlberg Radio
- ☐ 493 KS Oxygen Mask
- ☐ 509 Faultless Casters
- ☐ 518 Syring-O-Pak
- ☐ 532 Aluminum Splints
- ☐ 543 Floor Detergent
- ☐ 546 Solution Warmer
- ☐ 572 Vaseline Dressings
- ☐ 595 United Wire Mash
- ☐ 703 Hausted Stretcher
- ☐ 655 Conducote
- ☐ 656 Kard-a-Film
- ☐ 657 Anne Alt Bra
- ☐ 658 Do & Don't Card
- ☐ 660 Wallich Baby Band
- ☐ 661 Aveeno Band
- ☐ 662 Mary Jane
- ☐ 663 Storage Cabinet
- ☐ 664 Pneumatic Tourniquet
- ☐ 665 Vapor-All
- ☐ 666 Dresser-Desk
- ☐ 667 Anti-Fog Liquid
- ☐ 669 Elastic Adhesive Tape
- ☐ 670 Fibredown Underpads
- ☐ 671 Kidde Dry Ice
- ☐ 672 Life Size TV
- ☐ 673 Fluoradex
- ☐ 674 Speciment Diaper
- ☐ 675 Pathocide
- ☐ 676 Davidson Incubator
- ☐ 677 Hearing Aid
- ☐ 678 Rubberized Paint
- ☐ 679 Modocoll
- ☐ 680 Diluting Pipettes
- ☐ 681 Call-Button Holder
- ☐ 682 Shower Stall Base
- ☐ 683 Kodak X-Ray Hangers
- ☐ 684 Arrow Commode Chair
- ☐ 685 Cafecofe
- ☐ 686 Weck Prep Razor
- ☐ 687 Derma-Fresh
- ☐ 691 Ether Squibb
- ☐ 692 Sodasorb
- ☐ 693 Miss Curity
- ☐ 694 Sandoz Atlas
- ☐ 695 Therapeutic Nutrition
- ☐ 696 Hospital Equipment
- ☐ 697 Protective Equipment
- ☐ 698 Protective Paints
- ☐ 699 Freeman Supports
- ☐ 700 Continental Stat Sets
- ☐ 701 Noise Elimination
- ☐ 702 Baby Feeding
- ☐ 703 Uterine Canver
- ☐ 704 Trick Roping
- ☐ 705 Columbia Films

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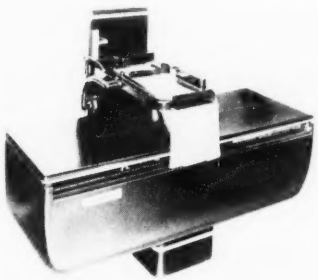
595. Reinforce impaired human tissues with United "Foundation Wire Mesh."—Available in weaves of specific strength and weight suitable for reconstructing weak and impaired tissues of each and all areas of the human body. Resistant to chemical and thermal changes. Eliminates serum accumulations. Has high degree of tolerance. Readily shaped into fixed, desired curves. Unequalled in tensile strength. United Surgical Supplies Co.

669. Elastic Adhesive Tape, made from uniformly woven cotton elastic backcloth, spread with surgical adhesive mass. Adhesive surface keeps tape in place with desired support and pressure. Stays where applied; molds itself to body, its stretch and pliability permit form-fitting bandage. Johnson & Johnson.

672. Life Size Television. New perfected projection television receiver gives pictures from three to forty-eight feet square. Two unit remote control model which may be separated by as much as 35 feet. Completely portable and easily adaptable to large or small areas. Expertly engineered receiver combined with a perfected optical system brings clear, steady picture quality. Arteraft Mantel & Television Co.



673. Fluoradex "180" X-Ray Table. Outstanding features are 90° Trendelenberg position, advantage of left or right-hand installation, 14" fluoroscopic screen travel across table, and 48" screen travel longitudinally. Also features control of all screen and table motions and locks directly on screen frame, offers complete radiation protection for the operator. Complete freedom from obstruction at floor allows doctor to work close to patient at all times. Westinghouse Corp.

674. New Urine Specimen Diaper. Easy and sanitary way to obtain urine specimens from infants. Made of non-irritating Vinyl, diaper ties around baby without necessity for pins. Specimen collects in special triangular reservoir and diaper is removed. Snipping off end of pointed tip allows specimen to drain into collecting vessel. Neat, clean, easy and economical—diaper used only once, then thrown away. American Hospital Supply Corp.

675. Pathocide, highly efficient general disinfectant, antiseptic, deodorant and cleanser. Leaves no odor, and is not injurious when used as recommended. Sample available. Cole Laboratories, Inc.

676. Davidson Incubator designed to give doctor and nurse complete view of infant while infant remains in complete isolation. Features built-in oxygen chamber, which is removable if high oxygen concentrations are not indicated; tilting arrangement so that infant's head can be raised or lowered up to a 25° angle; built-in non-electric asperator; build-in non-electric air circulator; humidity control. Constructed of stainless steel, aluminum and transparent lucite. Thermo Air Co.

(Continued on next page)

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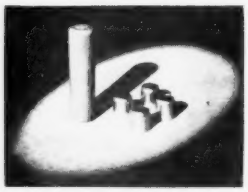


677. Plastic Case for Spare Hearing Aid Batteries. Holds four small mercury cell "A" batteries, measures only 3/4 inch in diameter and 2 3/4 inches in length. Fits easily into any pocket or purse. General Dry Batteries, Inc.

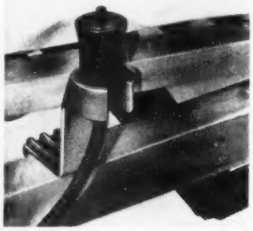
678. Revolutionary New Rubberized Paint offers almost unlimited range of colors through simple intermixes with standard units of measure. Texolite Duraval paint contains a controlled formula, combining a synthetic latex ingredient with special resin chemicals to produce velvet-like finish of remarkable durability. Requires no primers or sealers over most surfaces. Dries quickly, easy to clean, provides excellent coverage. United States Gypsum Co.

679. Modocoll, non-staining, non-fermenting wallpaper paste. Left over paste from a job can be put away and used again later. Colorless, odorless, leaves no marks. Never separates or gets lumpy. Unaffected by heat or cold. Needs no wall sizing whatsoever. Paper hanging equipment does not get gummy, cleans easily. Nu Paste Adhesive Corp.

680. New Type Red and White Blood Diluting Pipettes. 3 marks only, 0.5, 1 and 11 for white, 0.5, 1 and 101 for red. Eliminates confusion of intermediate graduations. Guaranteed for accuracy by U.S. Bureau of Standards, plus or minus 5% for red, and plus or minus 3.5% for white. Packaged 12 to a carton. American Hospital Supply Corp.

509. Faultless Condux Electrically Conductive Hospital Casters minimize static explosion hazards. Rubber expansion socket integral with double ball bearing swivel caster. Wheel is made of homogenous composition with electrically conductive properties.

681. New Call-Button Holder. Convenient device prevents damage to call-button and keeps cord off the bed. Holder slips on standard bed rails and slides along to any position. Keeps button from being dropped or crushed under headrest section . . . holds it upright. No tools required for installation, holder need not be removed for change of bed linen. American Hospital Supply Corp.



No. 28. Neva-Lose Bandage Scissors cannot be misplaced, for after use, a long, lifetime chain automatically returns the scissors to an attractive reel attached to the uniforms. Scissors are 4½" long and made of fine surgical steel, nickel and chrome.

682. New Type of Shower Stall Base. All-in-one-piece, seamless construction assures leak-free lifetime, does away with need for lead-pan insulation. Simulated basket weave design molded into surface is insurance against skidding accidents. American Cyanamid Co.

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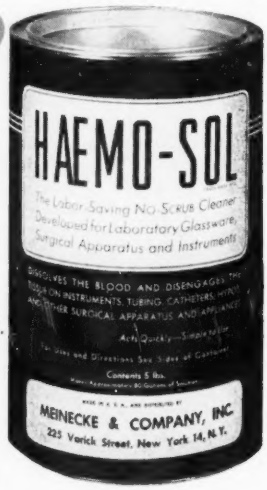
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HAEMO-SOL is an original product chemically formulated to meet exacting Operating Room and Laboratory needs. Contains no tri sodium phosphate, sodium meta silicate or caustic material likely to cause microscopic pitting of stainless steel. Haemo-Sol rinses absolutely clean, leaving no trace of any deposit or residue that may afford surface protection to bacteria and allow survival through autoclaving or other sterilization. Reusable!—Haemo-Sol's potency is unaffected by repeated usage.

Write for literature and samples

Prices per 5 lb. can.

12 cans $5.40 each
6 cans $6.08 each
1-5 cans $6.75 each

MEINECKE & COMPANY INC.

Serving The Hospitals Of America For More Than Fifty Years

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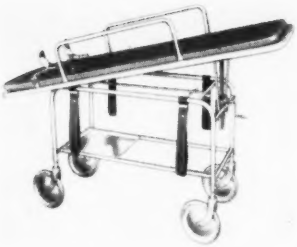


703. New Hausted Standard Stretcher. Adjustable so that top fits 3¾ inches over bed for safer and easier patient transfers. Enables just two nurses to transfer even the heaviest patient without harm or disturbance to patient or strain for attendant. Standard equipment with non-tilt stretcher are: safety side rails, restraining straps, Fowler attachment, power Trendelenberg position, shoulder stops, 4 caster combinations and special full size rails. Hausted Mfg. Co.

683. New Kodak X-Ray Processing Hangers. Improved clip design assuring accurate pin and hole alignment at all times. New pin design permitting better washing of film in clip areas, enables clips to stay cleaner longer. New clip shape, thinner, requiring less rack storage space. Loop guides to hold bow springs and top clips in line.

684. New Arrow Commode Chair available with infra-red baked brown enamel finish and standard gold oak toilet seat or baked white enamel finish and standard white enamel toilet seat. Comfortable, smooth, top quality toilet seats, top serves as back support when raised, top and seat rest against rubber bumpers. Hinges on top and seat permit easy removal of commode pail. Erie City Mfg. Co.

685. New Ingredient Improves Coffee, Adds 12 Cups Per Pound. Cafecofe, pure food ingredient, offered on a money back trial basis. Not a coffee substitute, but an ingredient to be added to any ground coffee, with much the same results in coffees as monosodium glutimate produces in meats. One pound of coffee, a half-ounce package of Cafecofe and an extra half gallon of water produces coffee with fuller body, rich aroma and better flavor.

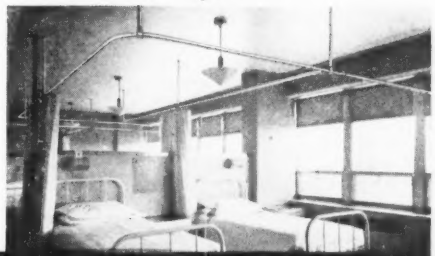
686. Weck Prep Razor gives finest, cleanest shave of any razor ever used in a hospital. No scraping scratching or irritating. Constructed in one piece, nothing to take apart, nothing to unscrew. Tooth guard offers complete protection, easy to wash clean. Does not clog, regardless of length of hair. Cutting edge compares in sharpness with that of a microtome or skin-grafting knife.

687. New Packaging for Derma-Fresh. Unique personalized bottle now packages well-known body massage. Hospital's name is ceramically marked in fresh green. Identification adds prestige and reduces loss to the hospital. American Hospital Supply Corp.

572. Vaseline Sterile Petrolatum Gauze Dressings. Therapeutically unique. Warrantably sterile. Suitable for instant application as Cover or Pack or Drain in wide variety of surgical uses. Processed and packed under complete aseptic technics; therefore dependably sterile without further preparation prior to use. Immediate application can be made any place, any time. Emollient, non-adherent, non-irritating. Chesebrough Mfg. Co., Cons'd.

(Continued on next page)

AMERICA'S GREATEST NAME IN HOSPITAL CUBICLES!



CAPITAL CUBICLES

AVAILABLE IN:

BRASS • STAINLESS STEEL
ALUMINUM, LUSTROUS FINISH

OUTSTANDING ADVANTAGES!

COMPLETE PRIVACY:

Installed in wards, semi-private, first aid, examination rooms; and in x-ray, hydrotherapy, dental, basal metabolism and other departments. Capital Cubicles provide maximum light and air, and enable nurses to render quicker medication and attention to the patient.

SMOOTH, EFFICIENT OPERATION:

Patented features of Capital Cubicles prevent hooks from catching or jamming, and assure quick, quiet, dependable operation.

EASY INSTALLATION:

Delivered complete with each cubicle and curtain keyed. Quickly installed with conventional carpenter's tools or, if desired, we will install at nominal cost.

LOW COST:

The initial cost of Capital Cubicles are the lowest on the market. *There are no maintenance costs to consider!*

CURTAINS:

Capital Cubicle curtains are of special closely-woven jean cloth, non-transparent and sanforized shrunk. In white and restful fast colors. Substantial rust-proof eyelets will not pull out or stain the cloth.

CURTAIN HOOKS OPERATE INSIDE TRACK . . CANNOT BE REMOVED OR LOST. CANNOT SCRATCH FINISHED SURFACE.

SEND FOR ADDITIONAL DETAILED INFORMATION

. . . include rough sketch of room, indicating bed positions. We will submit plans, specifications and cost. No obligation, of course.

CAPITAL CUBICLE CO., INC.

213 25th STREET, BROOKLYN 32, N. Y. • SOuth 8-1022

New Literature

694. "Atlas on Emotional Disorders". Discussions of functional disorders of various organs and their relationship to emotional disturbance are graphically illustrated with a new art technic. Booklet resolves, into concrete terms, the complex nature of the disturbance and shows how integrated drug action on the several divisions of the autonomic system is effective in re-establishing normal organ function. Sandoz Pharmaceuticals.

691. Ether Squibb. Booklet discussing stages of ether anesthesia, administration by inhalation, administration by other methods.

692. Sodasorb, a carbon dioxide absorbent described in 12 page booklet. For medical use in anesthesia, oxygen tents, metabolators. Dewey and Almy Chemical Co.

693. Folder containing prize-winning statements by entrants in Bauer & Black's Miss Curity Contest, a program designed to stimulate interest in the nursing profession.

One of a series currently appearing in leading surgical journals.

1870

"Antiseptic" surgery during the reign of the carbolic spray. From a rare old photograph. Courtesy of The Bettmann Archive.

THE FIRST year of Gudebrod's long history of specialization in the manufacturing of fine silk for sutures was way back in 1870. Gudebrod's sewing silk was widely used for suturing until the turn of the century when the first silk sutures, labeled "Surgeon's Silk," were introduced by Gudebrod.

Specialization for 82 years produces the finest sutures

1952

The transition from the "antiseptic surgery" of 1870 to the aseptic technics of 1952 is just one of the many forward strides of modern surgery.

THE FOREMOST manufacturer of non-absorbable sutures, Gudebrod has pioneered in the development of modern suture materials, contributing largely to the dependable excellence of present-day silk, cotton and nylon sutures.

Gudebrod is foremost with

Champion Serum-Proof Silk

Stronger, smoother, more uniform

Greater ease of handling

Maximum resistance to serum penetration

50% better after autoclaving

SPECIAL NOTE TO ALL O. R. SUPERVISORS!

Have you seen the attractive new leaflet on Gudebrod's Non-Absorbable Sutures? It's a handy size to keep in your files. Drop us a note for your free copy.

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PHILADELPHIA • CHICAGO • LOS ANGELES • BOSTON • DALLAS
first and foremost name in non-absorbable sutures

695. "Review of Literature on Therapeutic Nutrition." Authoritative, timely and concise compilation of the latest information on new technics, materials and procedures which have been developed in the field of nutritional therapeutics. The Stuart Co.

696. All Major Items of Hospital and Surgical Equipment manufactured by the Ohio Chemical & Surgical Equipment Co., along with pertinent installation data and dimensions, are featured in new, 28-page catalog.

697. "Civil Defense Protective Equipment," published by Mine Safety Appliances Co., shows equipment, including everything from stretchers to splints to the MSA Pneolator artificial respiration apparatus, in a table according to its function and its use by various services.

698. Penetrating, Protective Paints. Four page technical folder containing quick reference index to quickly determine most suitable coatings for rust prevention, chemical corrosion and dampness. The Wilbur & Williams Co.

699. Freeman Sudgical Supports, pocket reference catalog. Well illustrated.

700. Continental Rental Stat Sets. Pyrogen free. Sterile. Ready for use. Folder listing prices and descriptions.

701. Noise Elimination. Problem of industrial noises and their control is subject of new pamphlet issued by Industrial Acoustics Co.

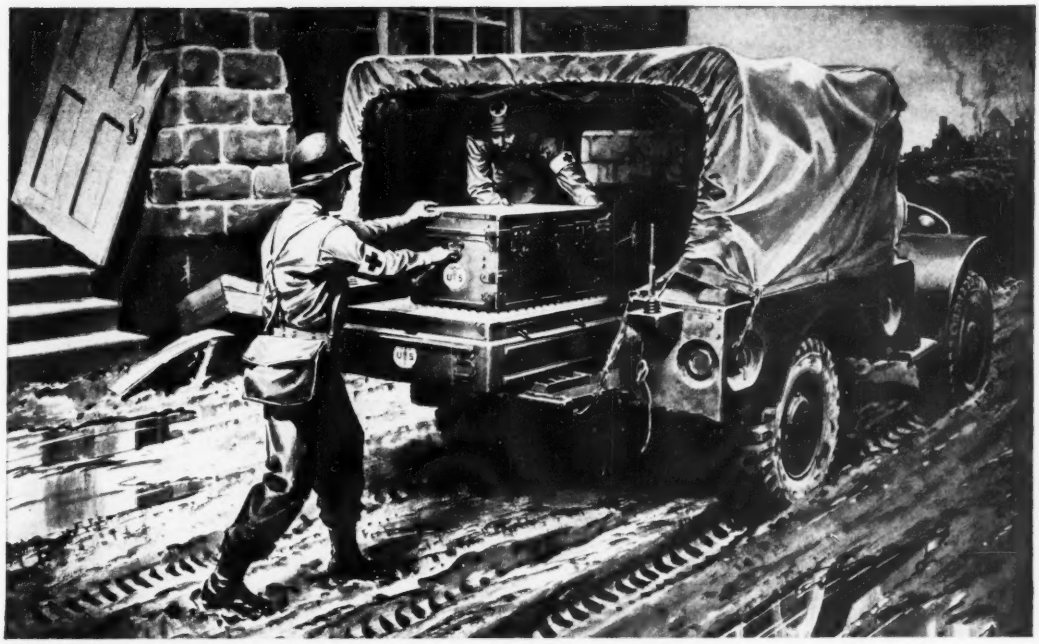
702. "Baby Feeding Made Easy." Helpful information for mothers and containing description of Davol Rubber Goods.

New Films

703. "Uterine Cancer: The Problem of Early Diagnosis." Illustrates the complete practicability of reducing deaths, particularly from cancer of the uterus and cervix, by adherence in general office practice to the routine pelvic examination of all adult women. 16 mm. Sound. Color. 21 minutes. American Cancer Society.

704. Trick and Fancy Roping. Film pictures technic of plain and trick roping as it can be taught to children in schools and to patients in need of rehabilitative exercise. Vernon J. Kraft Film Productions.

705. Catalog of University of Columbia Educational Films on medicine, physiology, nursing and public health.



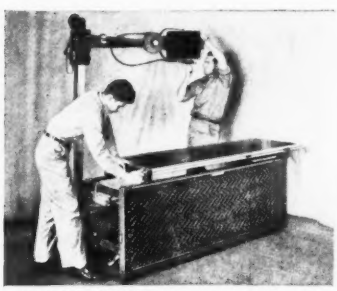
ARMED SERVICES ACCEPT PORTABLE FIELD X-RAY

New Picker Unit Operates Anywhere: Assembles in 5 Minutes

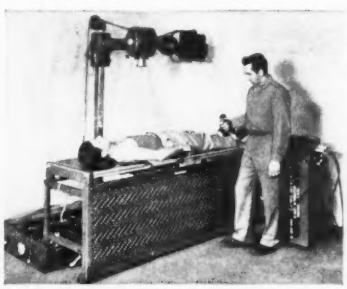
After months of rigorous proving tests, medical departments of all Armed Services have jointly accepted a new x-ray unit for operation in the field. Civil Defense authorities also see in its complete self-sufficiency an answer to the problem of providing x-ray facilities in disaster areas.

Like its forerunner, the U. S. Army Field X-Ray Unit of World War II, the new machine was designed and developed by the Picker X-Ray Corporation on its own initiative and at its own expense, with no development cost to the government. Quantity production is already well under way.

The unit is so portable and so self-sufficient that it can be used anywhere, even in forward areas. For transport it knocks down into two chests which are light enough to be moved by a medical team, compact enough to be carried in a jeep, or light truck, and rugged enough to be safely parachute-dropped. On arrival, the machine takes only five minutes to assemble for use in Mobile Field and Evacuation Hospitals. It will operate anywhere: on community power lines if available, or using a companion portable gasoline motor-generator. Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.



FIVE MINUTES is all it takes to assemble the new Picker machine; no tools are needed. The lid of the long chest becomes the table front: other parts unfold into position or are attached in sequence. Packing members become operating parts.



HORIZONTAL RADIOGRAPHY and fluoroscopy are equally easy. The unit will operate continuously for fluoroscopy at 5 MA. and will withstand storage conditions from 50° below zero to 120° F. at humidity up to saturation.

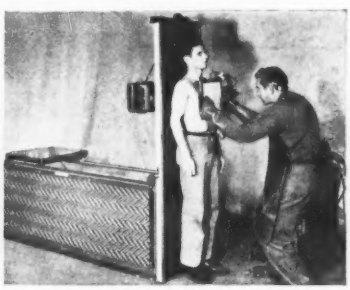
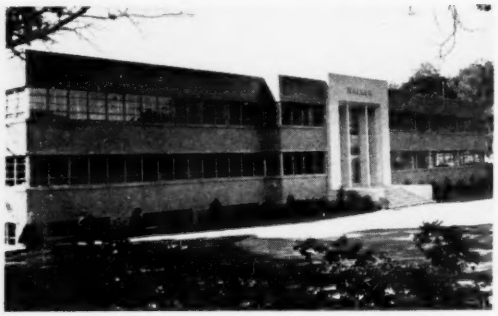


TABLE TOP SWINGS to vertical for fluoroscopy or radiography of upright patient. Sealed fluoroscopic screen is proof against warping or fungus invasion. Lead-rubber apron and gloves can be packed right into the same chest with the tubehead.

Trade Topics . . .

Walker Laboratories Dedicate New Building



Above: Walker Laboratories recently dedicated their new building in Mount Vernon, N. Y. One year in building the structure is 180 feet along the front and 100 feet deep. Approximately 38,000 square feet will be used for the manufacture of vitamins and related pharmaceutical products. After dedication ceremonies were held, guests were taken on guided tours of the entire building, including the laboratories, shipping and storage departments.

Cutter Completes Plant in Tennessee

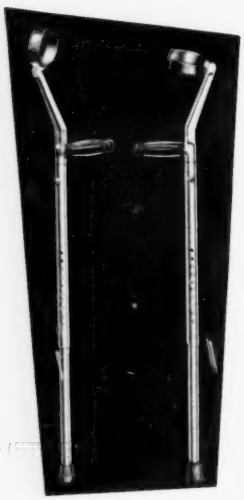
Completion of a new plant for the manufacture of hospital solutions was announced by Cutter Laboratories, Berkeley, California. Located in Chattanooga, Tennessee, the new laboratories completed testing operations and are ready for full-scale production to serve the eastern and growing southeastern markets.

In addition to hospital solutions, the Berkeley plant will continue to manufacture the biologicals and other medical products for which the company has become widely known since its founding in 1897.

American Hospital Supply Begins Additions

Above: The American Hospital Supply Corp., Evanston, Ill. has begun work on two additions designed to more than double its floor space. A two-story building of 30,000 sq. ft. will be constructed next to the main four-story building. In addition, American will take over a one-story plant located at the rear of its property. The combined first floor area of these three buildings, will be used for warehousing.

The second floor of the new building will become the company's general offices, while the top three floors of the old building will house the company's Evanston Division.



Orthopedic Canadian Crutches are also available in all-steel—with or without "Pogo" tips (resilient helical springs placed in the tips to absorb shock).

SPEEDS POST—OPERATIVE RECOVERY

By Eliminating Axillary Pressure

Orthopedic Canadian crutches mean complete freedom from armpit distress—greater comfort and easier handling.

First, they're all-aluminum—light and very sturdy. Arm bands are comfortably wide and readily adjustable to fit any forearm. Arm bands are also hinged—an extra feature that holds the crutch securely to the patient's forearm while he opens doors, lights a cigarette, etc.

For extra comfort bands are covered with felt and leatherette. Heavy rubber tips, arm bands and plastic covered hand grips are in matching colors. Easily adjustable for length over a 9" range in graduations of ¾". Weight 1¾ lbs. Write for complete details and prices.

Orthopedic EQUIPMENT CO.
150 Fort Wayne St., Bourbon, Indiana

Appointments

Roy Erickson has assumed the Presidency of the Royalty Development Corporation. Mr. Erickson resigned his position as Executive Vice-President and General Manager of Otis E. Glidden & Co.

Edwin B. McLean, M.D., has joined Cutter Laboratories, Berkeley, California, as Director of Clinical Investigation.

TO PROMOTE EARLY HEALING IN CHRONIC VARICOSE ULCERS

Tryptar

The Armour Laboratories Brand of Purified Crystalline Trypsin

In varicose ulcers, the immediate response to Tryptar is most satisfactory[1] . . . in many cases, complete healing is obtained.

Tryptar introduces a new therapeutic principle of selective physiologic debridement. Without attacking normal tissue, Tryptar digests only necrotic tissue and pyogenic membranes, induces satisfactory granulation and promotes healing within a short time . . . even in varicose ulcers of many years' duration.

Tryptar is entirely non-antigenic and non-sensitizing. It does not lose its effectiveness on repeated administration and is virtually non-toxic. Tryptar may be applied either as a powder or as a wet dressing.

Tryptar is supplied as a two-vial preparation: one 30 cc. vial contains 250,000 Armour Units (250 mg. of tryptic activity) of highly purified crystalline trypsin; the companion 30 cc. vial contains 25 cc. of Tryptar Diluent (Sorensen's Phosphate Buffer Solution), pH 7.1; plus plastic adapter for use with powder blower.

1. Reiser, H. G., et al.: Arch. Surg. 63: 568-575 (Oct.) 1951.

THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

—world-wide dependability—

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

HODGE PODGE

By Harry C. Phibbs

THE first time I saw the pageantry of death I was a little boy. An uncle brought me to see the funeral of the Irish leader, Charles Stewart Parnell.

There were bands, brass and fife and drum, all moaning and crying the lament of the "Dead March"—their drums muffled in crepe—their men marching a slow step as they paraded rank on rank in ceremonial before and behind the hearse of their lost leader.

The hearse, a glass and ebony show case for the casket drawn by six black horses, black caparisoned and plumed, drawing to his rest and stead the bearded squire who had led fierce forays of debate and resistance to English rule, only to be downed by the breath of scandal that rocked the Irish to their boot-heels, set brother against brother, father against son and the priests thundering denunciations from their pulpits that sent Parnellites marching with tight lips from the pews.

The uncle who had brought me to see this parade was a stout follower of Parnell. He was secretary of the Protestant Young Men's Home Rule Club. And all I could hear him mutter as the hearse passed was: "He's gone, he's gone, and so goes the cause."

Behind the hearse they led a horse with empty boots hanging from the saddle and behind this marched rank on rank the clubs and unions and groups that had muffled their debates and differences to honor the illustrious dead.

Another time was when word was spread on the dust blown by the wind that a big military funeral was stepping down the Circular Road.

The magic of a rumor had filled the windows with eyes and the road with urchins to watch the funeral of an Army man who had died.

The terrific pulse of the military band beat out the "Dead March" from Saul. The coffin was on a caisson drawn by six black horses. The soldiers marched in slow step, their rifles reversed and looking tall in the scarlet coats and black bearskin busbies.

Now if the poor fellow had lived he would have limped out his old age on a half-pay pension, but here was death and here was the pageantry, the military pace with death, to make death in uniform seem the more glorious. Always they fire three volleys over the grave when the chaplain has said "dust to dust and ashes to ashes." It is supposed to be that this is a survival of heathen custom to scare the demons away. Let us rather regard it as the royal salute a soldier makes to that glory that leads but to the grave.

The soldier is quite insistent on this, for no matter where the warrior falls they seek his body in the mud and sand of the battlefield to bring it back for the last slow, solemn rites and ritual and a place in the ranked rows of little markers of a military graveyard or a place beneath the noble slab where ever and always the armed sentry steps a religious beat before the tomb of the Unknown Soldier.

The American Indian had a brave and colorful pageant of death when the lost warrior was laid with his weapons and sacred things and, with the sacrifice of his pony, was sent on the journey to the happy hunting ground to the tum, tum, beat of a ceremonial drum.

The French have a liking for what the English call "wax works"—it is a set of groups moulded from wax posed to present a life-like representation of some historic event. Best known of these is Madame Tussauds in London where you can view anything from the new premier to the latest murder.

In Montreal they have a Musee of this character. It is located near the big shrine back of the mountains and essays to show the life and troubles of the early Christians in the Catacombs. Most of it is just this and that but there is one tableau that sticks in my mind. Outside the cell are the raging, sharp clawed and fanged beasts let loose by the Romans on this obscure and despised group of Jews and Greeks, who were following the teachings of this Jesus of Nazareth.

Inside in the Catacombs there lies a waxen figure to represent a Christian who had passed through the torture to eternity. The white-clad figure lies compose—the arms folded and laid with reverence over all one large branch of green palm.

It is a picture to hold the mind, of the quiet pageant that comes after the pulse has ceased.

In Latin countries they still make a slow parade after death. I remember a funeral in Cartagena—a hearse with plumed horses—a cortege of marching mourners, each draped in crepe walking behind the hearse. And all the passing crowd pausing to bow a head or lift a hat to make reverence to the one who had crossed the blue horizon to that bourne from which no man returns.

Even in our fast moving, motor driven age there is respect for death—they make it a recessional. The traffic lights blink red and green but the trucks and trolley cars stop—for here comes a funeral. Over all things it has right of way for death marks a pageant procession from the here to the hereafter.

Proved in Practice...

BOWEN LEG EXERCISER

• Designed to assist in passive abduction after cup anthroplasty, rehabilitation of paraplegics and many other cases requiring weight control exercises. Exercise board hinged at the center and angled to approximate the arc scribed by the legs. It moves freely in all directions on ball bearings, and has protractor adjustments for foot angle control.

ALL BOWEN INSTRUMENTS have proved their sterling worth in actual use in the country's leading hospitals. Precision made to approved design with the highest standards of workmanship from finest materials.

Write for Further Information

BOWEN & COMPANY, INC.

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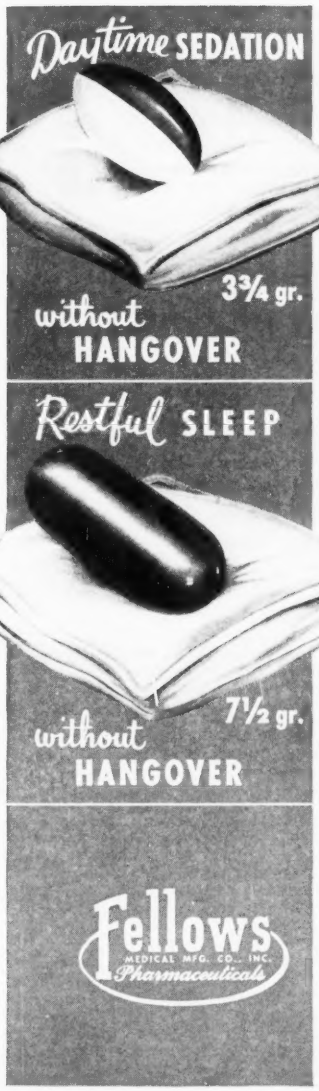
CAPSULES CHLORAL HYDRATE – *Fellows*

ODORLESS • NON-BARBITURATE • TASTELESS



HOSPITAL SIZES:

CAPSULES CHLORAL HYDRATE – Fellows
3¾ gr. (0.25 Gm.)
BLUE and WHITE CAPSULES
Bottles of 1000's

7½ gr. (0.5 Gm.)
BLUE CAPSULES
Bottles of 500's

3¾ gr. (0.25 Gm.) *BLUE and WHITE* CAPSULES CHLORAL HYDRATE – *Fellows*

Small doses of Chloral Hydrate (3¾ gr. Capsules Fellows) completely fill the great need for a daytime sedative. The patient becomes tranquil and relaxed yet is able to maintain normal activity.

DOSAGE: One 3¾ gr. capsule three times a day after meals.

7½ gr. (0.5 Gm.) *BLUE* CAPSULES CHLORAL HYDRATE – *Fellows*

Restful sleep lasting from five to eight hours. "Chloral Hydrate produces a normal type of sleep, and is rarely followed by hangover."[1] Pulse and respiration are slowed in the same manner as in normal sleep. Reflexes are not abolished, and the patient can be easily and completely aroused . . . awakens refreshed.[2-3-4]

DOSAGE: One to two 7½ gr., or two to four 3¾ gr. capsules at bedtime.

EXCRETION—Rapid and complete, therefore no depressant after-effects.[3-4]

pharmaceuticals since 1866
32 Christopher St., New York 14, N. Y.

1. Hyman, H. T.: An Integrated Practice of Medicine (1950).
2. Rehfuss, M. R. et al: A Course in Practical Therapeutics (1948).
3. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics (1941), 22nd printing, 1951.
4. Soilman, T.: A Manual of Pharmacology, 7th ed. (1948), and Useful Drugs, 14th ed. (1947).

CLASSIFIED

OUR 55th YEAR

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Medical Personnel Bureau
FORMERLY AENOE'S
9th floor • 185 N. WABASH • CHICAGO 1
• • • ANN WOODWARD, *Director*

If none of these opportunities meet your requirements, let us prepare an individual survey for you. Please ask for an analysis application form. Strictly confident.

POSITIONS OPEN

ADMINISTRATORS: (a) (Lay or Medical) 500 bed University hospital; new million Dollar program. To $14,000 plus large modern residence. (b) Lay or Medical; 200 bed brand new general hospital; to be completed fall, 1952; much sought after location; metropolis. (c) Medical; 250 bed hospital, general in character; excellent Tbc service; substantial salary; westcoast. (d) Medical; fairly large general hospital, expanding; newly created post; desirable town 30,000, famous resort, south-atlantic. (g) Medical or Lay; 250 bed teaching hospital; capitol city 160,000; W. (h) Lay; Assistant; 240 bed fully approved general hospital; town 50,000; NE. (i)

ADMINISTRATORS-NURSES: (j) Excellent clinic with 25 bed hospital; desirable town; Ill. (k) Brand new general hospital of medium size; Ind. (m) Fine little 32 bed general hospital; town 7000 not far from Des Moines. (n) Small Nebraska hospital; also Business Manager; consider man and wife combination. (o) 50 bed general hospital; desirable smaller college town; NW. (p) Consider well trained graduate nurse trained in anesthesia; 18 bed clinic hospital; Texas.

ADMINISTRATIVE STAFF APPOINTMENTS: (a) Business Manager-Chief Accountant; Brand new 200 bed hospital-clinic; very desirable, new town 12,000; SW (b) Comptroller; Full charge entire financial department; 500 bed fully approved general hospital; East. (c) Administrative assistant with superior accounting background; 120 bed general, voluntary hospital; fine college town 35,000; SE (d) Comptroller; well qualified in accounting department of twelve employees; fine Florida town 55,000. (e) Business Manager able meet public; accounting background; 190 bed California fully approved hospital enlarging to about 300 beds.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

Pittsfield Bldg., 55 E. Washington St.
Chicago 2, Illinois

POSITIONS OPEN

ADMINISTRATOR: South, 500 bed hospital associated with Medical School of large University. Require strong experience in public relations and business management. $8,000-$14,000 plus modern residence on grounds.

DIRECTOR OF NURSES: (a) East. 110 bed hospital in city of 17,000 easily accessible to New York City. (b) Southwest. 165 bed hospital in city of 70,000. Degree required. $6,000. (c) East. 215 bed hospital in city of 25,000. Will also act as principal of nurses training school. Degree required. (d) Middle West. 500 bed hospital in large city, fully approved. $7,200.

Personally Speaking

Dr. S. Howard Armstrong—Presbyterian Hospital, Chicago, was appointed Consultant to the Surgeon General, U.S. Public Health Service, in the field of mental health.

Abbie Allen—night supervisor of nurses, Montifiore Hospital, Pittsburgh, was honored by more than 300 associates of the hospital at a surprise party on her 75th birthday. She has worked at the hospital 41 years, and never missed a day.

Ellen Church—assumed duties as director of nursing and the school of nursing, Union Hospital, Terre Haute, Indiana, January 1. Miss Church was the first airline stewardess and originated the stewardess service for United Airlines in 1930.

Jacques Cousin—took over Feb. 1 as Director, Oakwood Hospital, Dearborn, Mich. He was formerly Assistant Director, Council of Rochester Regional Hospitals, Inc., Rochester, N.Y. He served his administrative residency at Harper Hospital, Detroit under **E. Dwight Barnett, M.D.**

THE MEDICAL BUREAU

Burneice Larson, Director
Palmolive Building
Chicago, Illinois

(a) ADMINISTRATOR: general hospital; 50 beds; resort and college town, Northwest; $5,000. (b) ANESTHETISTS: (1) Two; hospital affiliated 26-man group; college town, Northwest; $400, maintenance. (c) DIRECTOR OF NURSES: general 225-bed hospital; affiliated medical school; opportunity continuing studies; Midwest. (d) DIRECTOR OF NURSING SERVICE: new hospital; small size; residential town; near New York City. (e) EDUCATIONAL DIRECTOR AND NURSING ARTS INSTRUCTOR: small hospital; college town near Chicago; $6000, $4800, respectively, maintenance. (f) STAFF: (2) Several; new hospital general, 350 beds, affiliated university medical school; staff of 60 Board specialists; more than 100 residents in various specialties. (3) General hospital; Pacific Islands; $3900, maintenance. (g) SUPERVISORS: (4) Operating room; large, teaching hospital; staff, 16 nurses, 8 aides; $5000. (5) Operating room; modern well equipped hospital; minimum four years' experience; $6000; West Indies. (6) OBSTETRICAL: new 225-bed hospital; college town; Northwest; $400-$450. (h) SURGICAL NURSE: small hospital; resort town, North; $300, maintenance. (Please send for our ANALYSIS FORM so we may prepare an individual survey for you.)

Dr. E. Dwight Barnett—was appointed the first director of Columbia University's Institute of Administrative Medicine. This will be the first institution in this country to offer an advanced degree in administrative medicine and will conduct research in all phases of health administration. Dr. Barnett has been director of Harper Hospital, Detroit, since 1946.

Dr. Glenn P. Dewberry—is the new superintendent, Western Oklahoma Tuberculosis Sanatorium, Clinton, Okla. He was formerly assistant surgeon, Arkansas Tuberculosis Sanatorium, Booneville.

James P. Dixon, M.D.—is the new Health Commissioner of Philadelphia. He served as an administrative intern in Hospital Administration, Hospital of the Episcopal Church, Philadelphia. Dr. Dixon also was Director, City and County of Denver (Colo.) Dept. of Health and Charity under the Bureau of Health & Hospitals.

H. L. Dobbs—was named executive secretary of the new Hospital Commission of Kentucky Baptists and general administrator, Baptist Hospitals in Louisville, Lexington, and Paducah. He has been administrator, Kentucky Baptist Hospital, Louisville, for 16 years.

Dorothy Drerup—was elected superintendent, Cape Osteopathic Hospital, Cape Girardeau, Mo. She had been acting superintendent since the resignation of **Lee McGlothlin.**

Germaine Febrow — former director of public relations, St. Luke's Hospital, Chicago, is now associated with the Illinois Hospital Association in Chicago.

Walter Golding—has been named superintendent, Memorial Hospital, Colorado Springs, Colo. He succeeds **H. F. Zimoski, Jr.**

S. Cantey Gordon—has resigned as superintendent, Orangeburg (S. C.) Regional Hospital, to become administrator of the new Greer Unit of Greenville (S. C.) General Hospital.

Dr. Clifford G. Grulee—member of the consulting staff, Presbyterian Hos-

(For Additional Classified see page 64)

pital, Chicago, was elected Honorary President for life by the American Academy of Pediatrics.

Gordon A. Hardwick—was elected chairman, Hospital Council of Philadelphia, succeeding **J. Hamilton Cheston** who resigned. Hardwick is president of Graduate Hospital, Philadelphia.

James Hatfield—has been appointed assistant manager, VA Hospital, Altoona, Pa. He was formerly chief of special services, Beckley (W. Va.) VA Hospital.

M. J. McDaniel—has been appointed Director, Coffee County Hospital, Douglas, Ga. and will assume his new position around March 1. Entering his twenty-fifth year in hospital work, Mr. McDaniel is now administrator, Memorial Hospital, Adel, Georgia.

Dr. George O. Pratt—has been appointed manager, VA Hospital, Brooklyn, N.Y. He was formerly manager, VA Hospital, Manchester, N.H.

Dorothy A. Vernstrom—was appointed Director of the School of Nursing and Nursing Service, Peter Bent Brigham Hospital, Boston, Mass. She was formerly Assistant Director of Nursing, Memorial Hospital Center for Cancer and Allied Diseases, New York City.

The November, 1951 issue of HOSPITAL TOPICS incorrectly listed Miss Vernstrom as coordinator of nursing education, Illinois Department of Registration and Education. **Gertrude M. Steir** assumed this position succeeding **Elizabeth H. Wright**, who resigned.

VA Appointments

Mary Aurelia Killian—formerly a supervisor, has been assigned as Assistant Chief, Nursing Service, VA Hospital, Tomah, Wis.

Ruth G. Rochelle—has been transferred to the VA Hospital, McKinney, Texas, as Assistant Chief, Nursing Education. She was formerly a nursing supervisor, VA Hospital, North Little Rock, Ark.

Elizabeth A. Glander—has been assigned as Assistant Chief, Nursing Service, VA Hospital, Montgomery, Ala.

Laura M. Volkman—has been transferred to the VA Hospital, Grand Island, Nebr., as Assistant Chief, Nursing Education. She was formerly an instructor, VA Hospital, Wood, Wis.

Leon I. Gintzeg—formerly Assistant Chief, Nursing Education, VA Hospital, Knoxville, Ia., has been transferred to VA Hospital, Downey, Ill. in a similar position.

Mildred M. Caldwell—has been transferred to the VA Hospital, Ft. Lyon, Colo. as Chief, Nursing Service. She was formerly Assistant Chief, Nursing Service at the VA Hospital, American Lake, Wash.

Helen L. Haegele—is Chief, Nursing Service, Ft. Harrison, Mont. VA Hospital. She was formerly the Assistant Chief there.

Margarita M. Farrington—formerly Surgical Nursing Supervisor at the VA Hospital, Framingham, Mass., is now the Assistant Chief, Nursing Service.

Suzanne S. Dziak—is the Assistant Chief, Nursing Education, VA Hospital, Cleveland, Ohio. She was formerly an instructor there.

Gertrude E. Toyer—is the Assistant Chief, Nursing Service, VA Hospital, Boise, Idaho.

Evelyn C. Humlicek—is the Assistant Chief, Nursing Education, Omaha, Neb. VA Hospital.

Katherine D. Morris—is the assistant Chief, Nursing Education, at the Montrose, N.Y. VA Hospital. She held a similar position at the VA Hospital, Chillicothe, Ohio.

Frank J. Waling, Jr.—is the Assistant Chief, Nursing Education, at the VA Hospital, Lincoln, Nebr.

Irma M. Olson—formerly Acting Assistant Chief, Nursing Education, VA Hospital, Beckley, W. Va., is now Assistant Chief, Nursing Education.

Florence B. Bash—is Assistant Chief, Nursing Service, Des Moines, Ia. VA Hospital.

Martha Scudder—has been assigned as Assistant Chief, Nursing Service, Big Springs, Texas VA Hospital.

Mary J. Cross—formerly a Nursing Supervisor at Excelsior Springs, Mo. VA Hospital, is now Assistant Chief, Nursing Service.

Esther W. Johnson—is Assistant Chief, Nursing Education, VA Hospital, Portland, Ore.

Ruth Ganiere—formerly an Instructor, Vancouver, Wash. VA Hospital, has been assigned as Assistant Chief, Nursing Education there.

J. Lou Turner—has been assigned as Assistant Chief, Nursing Service, VA Hospital, Lyons, N.J.

Verna M. Hazelton—is Chief, Nursing Unit, VA Regional Office, Oklahoma City, Okla.

Elizabeth A. Moore—has been appointed Chief, Nursing Unit, Regional Office Clinic, VA Center, Waco, Texas.

(Continued on next page)

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PERSONALLY SPEAKING continued

Dr. Henrietta Herbolsheimer—chief of the division of maternal and child health, Illinois Department of Health, has been appointed Assistant Professor of preventive medicine, University of Chicago Medical Center. She recently served as a deputy director, Illinois Civil Defense Agency, and had charge of planning medical and casualty services for the state's defense plan.

Dr. J. M. Hershey—has been appointed hospital medical consultant, office of medical defense of the N. Y. State Health Dept. He resigned his position as assistant deputy minister of Public Health and Director of Regional Health Services, Regina, Sask. to accept the new job.

Harry G. Higgins, Jr.—has been appointed administrator, University of Illinois Research and Educational Hospitals. He served as comptroller, Miami Valley Hospital, Dayton, Ohio, from 1946-1950.

Kenneth E. Holmquist—was named superintendent, Minneapolis (Minn.) General Hospital after serving as administrative assistant at University Hospitals there.

Sister M. Hyacinth—was appointed superior-administrator, St. Anthony's Hospital, St. Louis, Mo. to replace **Mother M. Maura** who died.

Laura G. Jackson—has been appointed Coordinator of Public Relations and Publications for the International College of Surgeons, Chicago. She is also Associate Director, Program in Hospital Administration and lecturer, Northwestern University, Editor of the university's **Hospital Administration Review**, and Assistant to the Chairman, Tri-State Hospital Assembly. From 1937 to 1951, Miss Jackson was Director of Public Relations, American College of Surgeons.

Margery Jarmon—has been appointed Director of nursing service and the school of nursing, Bishop Clarkson Memorial Hospital, Omaha, Nebr. She succeeds **Irma Roberts** who resigned last summer.

Dr. George Johns—superintendent, Rosewood Training School, Owings Mills, Md. for 8 years, has joined the staff of State Hospital No. 4, Farmington, Mo. Johns was superintendent, St. Louis City Sanitarium for 20 years and was the first superintendent of the St. Louis County Training school for the mentally ill.

Everett Johnson—was appointed superintendent, Chicago Memorial Hospital, succeeding **Josephine Blalock.**

Dr. Simon O. Johnson—psychiatrist and superintendent, Lakin (W. Va.) State Hospital, received an Alumni Citation for meritorious achievement at the Johnson C. Smith University homecoming celebration. Dr. Johnson is one of two Negroes who heads a mental institution in the United States.

Dr. Gerald F. Kempf—was appointed superintendent, Indianapolis General Hospital. **Dr. Henry G. Nester** was named to succeed Dr. Kempf as city health director. Both took their new posts Jan. 15, when the resignation of **Dr. Charles W. Myers**, General Hospital head for the last 20 years, became effective.

Dr. Hilda H. Kroeger—has been named administrator, Elizabeth Steel Magee Hospital, Pittsburgh. She was formerly assistant director, Grace-New Haven (Conn.) Community Hospital. Dr. Kroeger is one of the few women doctors in the U.S. to become administrator of a large hospital.

Lowell C. Like—manager, Ft. Bayard, N. Mex. VA Hospital, has been

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transferred to manage the Walla Walla, Wash., VA Hospital. **Eugene K. Ricker** will succeed Mr. Like at Ft. Bayard.

Regan Long—has been named administrator, Forest County (Miss.) new $1,100,000 hospital now nearing completion. He was formerly associated with Kahn Memorial Hospital, Marshall, Texas.

Col. Agnes A. Maley—was appointed director of Army nurses in the European command. She will succeed **Col. Alta Berninger.**

Dr. John B. McHugh—will become manager, VA Hospital, Kansas City, Mo., when construction of the new hospital is completed. He will succeed the late **Dr. Willis M. Manney** who had previously been designated manager.

Betty Whalen Mangum—was promoted to superintendent of nurses, Arkansas State Hospital, Little Rock. She succeeds **Grace Graham** who recently resigned.

Tom Norton—administrator of Wichita (Okla.) General Hospital for three years, has resigned to accept a position as production manager with a major aircraft company.

Robert M. Schnitzer—is the new director, Middlesex General Hospital, New Brunswick, N. J. He was formerly administrator, Lutheran Memorial Hospital, Newark, N. J. Mr. Schnitzer succeeds **John L. Brown** at Middlesex, who is now administrator, Rockford (Ill.) Memorial Hospital.

Joseph Terranova—has been named administrator of the new Medical Clinic of Rockford, Ill. He was formerly assistant superintendent, Rockford Memorial Hospital.

Mrs. Paul Tidball—has been named manager, Cleveland County Memorial Hospital. She will work with the board of governors in setting up the staff of the new hospital scheduled to open early this year.

Dr. Derrick T. Vail—professor and chairman, Department of Opthalmology, Northwestern University, is the chairman of the Special Medical Advisory Group of the VA for 1952. He succeeds **Dr. Charles W. Mayo,** Mayo Clinic, who had been chairman since the group was organized six years ago. **Dr. Franklin D. Murphy**, chancellor of the University of Kansas is vice chairman, and **Dr. Brian B. Blades,** professor of surgery, George Washington University, is secretary.

Claude Weeks—has been named superintendent, Newberry County (S. C.) Memorial Hospital. He succeeds **J. W. Henderson** who resigned effective Dec. 31.

Major Nell Wickliffe—has been appointed Chief of the Women's Medical Specialist Corps, U.S. Army. She succeeds **Col. Emma E. Vogel** who retired November 30. Major Wickliffe automatically advances to full colonel with the new position.

Joseph A. Williamson—was appointed administrator, Hunterdon Medical Center, Flemington, N. J. He was formerly assistant administrator, Sharon (N. J.) General Hospital.

Preston Ray Woodham—has been named assistant administrator, Baylor University Hospital, Dallas, Tex. He received his Master's degree in hospital administration at the University of Minnesota in 1950.

Dr. Linus A. Zink—is the new manager, Mt. Alto VA Hospital, Washington, D. C. He succeeds **Dr. Charles**

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M. Griffith who retired December 31 after more than 34 years of Government service.

New Officers Chosen by State Hospital Associations

Connecticut—James M. Dunlop, administrator, Bridgeport Hospital, was named president-elect of the Association. **Edward K. Warren**, Chairman of the Board., Greenwich Hospital, is president.

Illinois—George H. Van Dusen, administrator, Christian Welfare Hospital, East St. Louis, is president-elect of the Association. **Erwin W. Wegge**, Business Manager, Moline Public Hospital, is president.

Missouri—Dr. David Littauer, Kansas City, was chosen president-elect of the Association. **C. Steacy Pickell**, Kansas City, took over the office of president.

Virginia—Homer E. Alberti, administrator and treasurer, Winchester Memorial Hospital, was named president-elect of the Association. **C. P. Cardwell, Jr.**, director, Hospital Division, Medical College of Virginia, will assume the presidency in April of this year.

Nursing School Accredited

The division of nursing, St. John College, Cleveland, Ohio, has received full accreditation by the National Nursing Accrediting Service. The division was organized in 1947 and graduated its first class last June, granting the degree of bachelor of science in nursing. **Sister M. Edith** is Director and **Dorothy M. Brinker**, Associate Director.

Deaths

Mary Alberta Baker—81, former vice president A.H.A., died Nov. 17. She was the first superintendent, Putnam Memorial Hospital, Bennington, Vt., starting in 1917 and serving until her retirement in 1947. In 1944 the A.H.A. voted her an honorary life membership for her more than 40 years service.

Dr. Beatrice H. Brickett—87, retired superintendent, Massachusetts Women's Hospital, and a pioneer among women in medical circles, died Dec. 10 in Newton Center, Mass.

Rear Admiral Clyde W. Brunson—56, medical officer, 13th Naval District, died Dec. 20 aboard a Navy transport plane. He was en route east with a number of wounded Marines when he suffered a heart attack. Admiral Brunson was awarded a presidential citation for his part in the defense of Pearl Harbor and served aboard the hospital ship Solace during the South Pacific campaign.

Dewey Brownlow Henson—47, owner of the Samaritan Treatment Hospital, South Charleston, W. Va., died Dec. 27.

Dr. Oscar B. Hunter, Sr.—63, of Washington, D. C., Vice President of the A.M.A., died Dec. 19.

Dr. Margaret Mace—87, who retired last year after 35 years of operating a public hospital bearing her name in North Wildwood, N. J., died Dec. 16.

Dr. Dallas B. Phemister—69, world-renowned surgeon who established the department of surgery, University of Chicago medical center, died Dec. 28. Dr. Phemister was a past president of the American College of Surgeons, the American Surgical Association, the Society of Clinical Surgery, and the Chicago Pathological Society. He was made an honorary fellow of the Royal College of Surgeons (England), and awarded the Legion of Honor by the French government at the meeting of the International College of Surgeons in Paris last fall.

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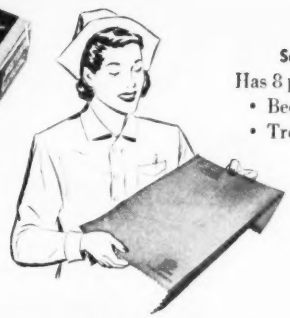

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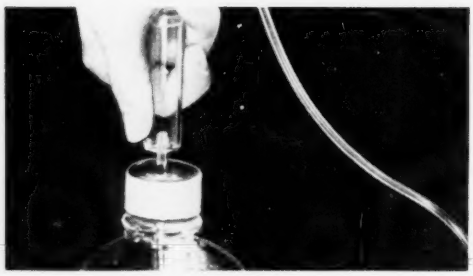

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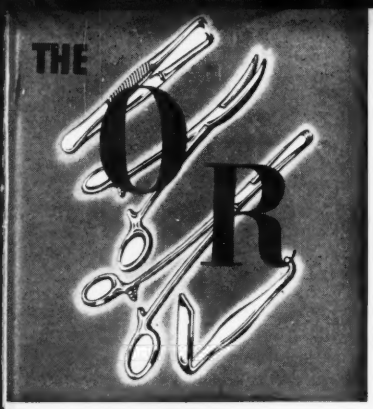


A section of special interest to operating room supervisors, surgeons, nurses and other O.R. personnel. Contributions are welcome.

• This entire O. R. Section is made available in the interests of Operating Room Personnel by Ethicon Suture Laboratories, Inc.

Surgical Service from viewpoint of the Administrator

By Dr. J. A. Katzive
Director
Mount Zion Hospital
San Francisco

Presented at the Hospital Standardization Conference held during the Clinical Congress of the American College of Surgeons, San Francisco.

Standards

THE VIEWPOINT of the administrator with reference to the surgical service is concerned with standards, physical plant facilities, surgical equipment and supplies, qualified personnel, safety and welfare of the patient, medical-legal aspects, teaching and economy.

The governing body, with the assistance of the medical staff, appoints a qualified surgical staff and lays down general policies and regulations concerning standards to be maintained. The administrator sees that these policies are followed; the medical staff sees to their actual execution.

Some hospitals have found it desirable to appoint a credentials committee of the staff to evaluate the qualifications of a surgeon and if necessary limit him to surgical procedures which the committee considers him qualified to perform.

The credentials committee usually considers a surgeon who is a member of a specialty board fully qualified in his field, having passed an examination and fully satisfied a board of qualified examiners as to his ability. The ability of surgeons who have not as yet been qualified by a board, is determined through observation of their work. If the observer is satisfied, the surgeon is approved for the procedure or general classification of procedures. If it is felt that he is not qualified, the credentials committee may require further review and may determine that he should not be encouraged to qualify himself; or it may determine that the basic aptitudes and encourage him to obtain further training. Surgeons are advised of their classification and are expected to schedule surgery accordingly.

The administrator keeps an individual card record of every surgeon, a duplicate is kept in the operating room supervisor's office. When an operation is scheduled the supervisor checks the surgeon's card for his classification. If he is to be observed in a procedure, the chief of staff designates a qualified observer who reports his findings to the credentials committee through the administrator. If the surgeon is not approved for the scheduled procedure he is so advised and encouraged to take the matter up with the credentials committee.

In regard to legality of this procedure, it should be pointed out that the Board of Directors has the responsibility of selecting the best qualified physicians as staff members and determines what members will or will not use its facilities. The board advises the surgeon that he may not use the hospital facilities for such procedures as he desires to perform. That does not preclude his privilege of doing this procedure in some other institution.

Physical Facilities

It is the responsibility of the administration to provide surgeons with a working plant. Such a plant will provide all structural facilities, such as ventilation, lighting, humidity and such mechanical features as pressure and suction.

Personnel

It is the administrator's responsibility to see that sufficient personnel is available to adequately assist the surgeon at the operating table. While in the operating room this personnel is actually under the direct supervision and instruction of the surgeon.

The operating room supervisor and all those under her will do everything possible to assist the surgeon in line

SURGICAL SERVICE

continued

with established policies. She has the direct responsibility to see that these policies are executed.

Teaching

Residents, interns, and student nurses in the operating room are to assist the surgeon, but are primarily assigned to him for the purpose of acquiring training so that they themselves may eventually qualify as surgeon or surgical nurses. We have an obligation to the house staff to see that they receive every opportunity for training and education. There should be grand rounds, wet and dry clinics, and above all, opportunities to perform surgery under close and active supervision of qualified surgeons.

In small hospitals, it would be desirable to affiliate with a large medical teaching center to provide the more senior members of the surgical house staff opportunities to observe other surgeons in the operating room.

Safety and Welfare

The administrator is concerned with the safety and welfare of the patient. In addition to safeguarding the patient against mechanical failure, explosion hazards, he must exercise every care and caution in the selection of all personnel in the operating room. To protect the surgeon and hospital, he must ascertain that adequate consent forms are provided and completed by the patient. He must make certain that proper records are kept. Surgeons are required by regulation of the medical staff to show a preoperative diagnosis before the patient comes to the operating room; and a postoperative diagnosis is recorded, based on the report of operation dictated after surgery.

"...he did go home after his operation... but then he got your bill!"

All tissues removed by the operation must be sent to the pathologist for examination. He has a moral and ethical obligation to report any persistent discrepancy between the pre-operative and post-operative diagnoses and the pathological diagnosis of the tissue examined. In this connection, the medical auditor will make invaluable contributions to the effort of maintaining high standards.

Economy

Hospitals today are more than ever conscious of the need for economy in the operating room. There are opportunities for saving if an effort is made. Some surgeons are found to be more economical than others in the use of surgical supplies, such as expensive suture material and in handling costly and delicate instruments. In the last analysis, waste in the operating room reflects on the patient, because costs are eventually borne by him.

Some of us become too preoccupied with administrative detail better delegated to assistants and department heads, as a result of which we often do not have sufficient time for high-level thinking, planning and attention to maintenance of standards. Because we appear to be concerned primarily with maintenance, housekeeping, and accounting problems, the impression is created among some of the medical staff men that that is the sole responsibility of the administrator, so that when he does concern himself with hospital and medical standards, questions arise in the minds of the staff as to whether or not he is stepping out of his province.

Education

There is a need occasionally to educate the medical staff to the realization that administrators have the duty to see that the highest medical and surgical standards are maintained in the hospital, so that when he does make recommendations to that end, suggestions will be well received. With such an understanding, there should be little opportunity for personal issues to arise between the staff, administrator, and the operating room supervisor.

It is through such coordinated efforts of the surgeon, the operating room personnel, and the administration that such great strides have been made in the advancement of the surgical service in the hospital.

Dallas A.O.R.N. Elects New Officers

THE Dallas Operating Room Association elected officers for 1952 at a meeting January 8th at Parkland Hospital. Mrs. Virginia Nelson, Baylor Hospital, will serve as president; Miss Mary K. Baskerville, Methodist Hospital, vice-president; Mrs. Mary Fox, Dallas VA Hospital, secretary; and Miss Therla Woods, Parkland Hospital, treasurer.

The Association is revising its Constitution before answering numerous requests for copies from other groups in Texas who wish to form a similar organization. The pace-setter Dallas group now has 50 members.

The December meeting of the group was a Christmas party, held at the home of June Smith, one of the members. It was primarily a social gathering, but it was decided that tags with name and hospital affiliation would be worn by all those attending the meetings to facilitate getting to know one another. The group also discussed current membership and ways of renewing interest for the new year.

Are YOU Careful About Reading the

LABELS

This editorial, reprinted from the J.A.M.A. is of interest to all concerned with the care of patients. Its subject matter is of particular interest to those working in an operating room where so many of the drugs administered are given in times of emergency when confusion, fatigue and haste make the problem of proper identification of drugs more acute.

FROM time to time accidents are reported because of failure to read labels of potent drugs before these drugs are injected. While it is true that a physician is generally advised against the use of a drug unless he is familiar with its action, the fact remains that many potent remedies which are familiar to him are made available in a variety of dosage forms and doses which are not always readily apparent unless the label is examined carefully. Attempts have been made from time to time by, for example, the use of colored labels and cautionary statements to warn the user at a glance of the nature of the product he is using. Various suggestions have been made by physicians, pharmacists, drug manufacturers, law enforcement officers, hospital officials and others, but so far a completely satisfactory solution has not been offered. It is still necessary for the physician or whoever uses or prepares a drug to carefully read a label to learn what he is using. Some have proposed the use of different colors, for example, red for intravenous use only, white for subcutaneous and intramuscular use and blue for intravenous, subcutaneous or intramuscular use. Others have suggested tinting the solutions. Of course, the use of colors is limited by memory and by the number of colors available. It probably never would be possible to get sufficient distinctive colors to differentiate all solutions, let alone the variety of strengths of each drug. As has been pointed out by some, the coloring of liquids probably would only encourage laziness, indifference or a false sense of security. Others have proposed the use of diagonal lines.

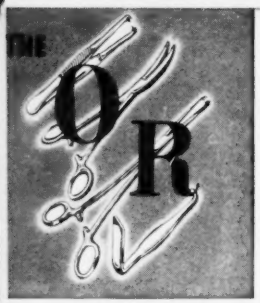
Need for Informative Names

Many educators, practicing physicians and organized groups, such as the Council on Pharmacy and Chemistry, have attempted to draw attention to the hazards associated with the use of dangerous drugs, to the need for using informative names and for providing, if possible, adequate cautionary statements on labels. However, the consensus probably can be summarized thus: There is no easy shortcut. Nothing can take the place of constant vigilance and careful reading of labels. It cannot be too strongly impressed on all who handle drugs that any drug can be dangerous if incorrectly used and that reliance cannot necessarily be placed on someone else to do the reading and provide adequate safeguards. One can avoid errors only by acquiring a habit of deliberately checking the label of any drug used rather than relying on its appearance or on the verbal statement of an associate. The manufacturer or whoever prepares drugs should label them properly, and the person administering the drug should read the label. If a solution or other dosage form looks questionable it should be discarded, or if a label becomes detached and one cannot be sure of the nature of a drug it should not be used. The use of colors alone would not solve the problem, as there are comparatively few persons who have a sufficiently good color perception and memory for shades to allow them to safely differentiate between say twenty or thirty colors.

Attempt to Create Significant Labels

Many drug manufacturers have given careful consideration to the creation of labels which would be as significant as one could make them, but these efforts depend in the final analysis on the physician's reading the label before he uses a drug. While the fear of litigation and the possibility of heavy damages may have in some instances a sobering effect on the attentiveness of a physician, part of the remedy lies in impressing on medical students, interns and residents the dangers associated with the misuse of drugs, developing a heightened awareness of the possibility of danger in the mind of the practitioner and the encouragement of habits in the hospital and in private practice which tend to keep to a minimum possibilities of confusion. The misuse of a drug may mean loss of a life. It is the responsibility of the medical profession to save lives if possible, and anything that it can do to prevent an accidental loss of life supports its primary objective.

Editorial Reprinted from the Journal of the A.M.A., 143:10, 899



Surgical Notes

James F. Fleming, M.D.

Peritoneal Irrigation

Other than a short period of irrigation during an operative procedure, peritoneal irrigation is not widely employed. The procedure does, however, have a definite field of usefulness.

In the Journal of the *Oklahoma State Medical Association*, Muirhead, of Dallas, outlines the indications and a simplified method of employing this therapeutic measure.

In selected cases of acute renal failure, mainly lower nephron nephrosis, the procedure may be found effective as a "desalting" measure.

In potassium intoxication, irrigation of the peritoneal cavity offers a rapid means of relieving the condition. The fluid employed is preferably without potassium.

Anasarca can be relieved by peritoneal irrigation within a matter of hours. For this purpose, glucose is added to the irrigating solution for its osmotic effect.

The procedure is fairly simple. A polyethylene tube 4 mm. in diameter and with multiple perforations near its end is inserted through a trocar. The trocar is removed and a purse-string suture secures the tube. For the other end of the tube, a large bore needle is cut short and made to fit snugly into the tube so that the proximal end can be jammed tightly onto the distal part of the hilt. A three-way stopcock is inserted into the needle, and input and outflow tubes are attached.

Three liters of irrigating solution is then introduced. Subsequently, one liter is left as a priming volume.

The fluid is allowed to run rapidly, and is left in the abdomen an hour and a half. The stopcock is then reversed and the fluid allowed to drain without suction.

Foreign Bodies

Barrett, of Houston, reports on a series of 108 cases of foreign bodies in the air and food passages in A.M.A. *Archives of Otolaryngology*, December, 1951.

Using the endoscopic technic, he found the mechanical head rest satisfactory for most procedures in adults, but found it necessary to hold the head in children as a rule. The anesthesia employed for adults was local, but he used general anesthesia for 25 of the children. There were 56 adults in the series and 52 children.

Of interest is the type of foreign bodies encountered. Most frequently seen were bones, which constituted 38 percent of the total. Coins were next, constituting 20 percent, and meat particles were 11 percent. A fourth of the entire series were chicken bones. All tracheobronchial foreign bodies were in children under the age of 5.

Of clinical importance is the author's evaluation of the cause of delay in diagnosis of tracheobronchial foreign bodies. Due to the age of these patients, the history is often of no value, and this fact was prominent in delaying the diagnosis. Other factors were failure to correlate the findings with those of a foreign body, and masking of symptoms by chemotherapy and antibiotic therapy.

Tracheotomies were necessary only twice in the series, one for a pine cone impacted in the larynx and the other for a large bone in the trachea. Two open safety pins were lost in the stomach but passed through the intestines without complication.

Usefulness of Hyaluronidase

Much has been written on the "spreading factor" and Swenson, of Omaha, summarizes the clinical application of this factor in the *Nebraska State Medical Journal*, January, 1952.

Perhaps the greatest application is in connection with hypodarmoclysis, according to the author. Almost any type of non-toxic agent can be given subcutaneously with greater speed and range of diffusion. Glucose solutions up to 10 percent, protein hydrolysates, and even plasma, are absorbed rapidly.

Drug administration may also be facilitated by the administration of hyaluronidase. Among the drugs mentioned are penicillin and heparin. The method permits hypodermoclysis at intravenous speed, with the increased simplicity.

Hyaluronidase has been used to facilitate removal of viscous pleural fluid, and has been injected into asicitic fluid to encourage its absorption and elimination through the kidneys, aided by a diuretic.

Used in conjunction with local anesthetic agents, hyaluronidase produces a much larger area of anesthesia. In addition to assisting in the production of anesthesia for surgery, this type of technic may be employed in the treatment of sprains and also in selected cases of backache.

Automatic Unit for Continuous Spinal

A motor driven unit for continuous spinal anesthesia is described by deCiutiis and Fierro of New York in *Anesthesiology*, November, 1951.

The unit, known as the "Injectomat," is described as filling the gap between the traditional delivery of small volumes of drugs by a hand-operated syringe and the slow controlled administration of large volumes of fluids by the gravity drip method.

The injection by means of the instrument may be slow or fast, continuous or intermittent, of small or moderate volumes of fluid. The syringe is held in a self-centering holder which accommodates up to 100 cc. syringe. Flexible tubing connects the syringe with the needle, and the fluid is intermittently injected at short and fixed intervals of a few seconds by periodic pulsations.

Rate of fluid delivery is controlled by synchronized motors and controls. A signal light protects against obstruction to flow or continuation after the syringe is empty.

By means of this unit, 34 patients to date have received satisfactory continuous spinal anesthesia of one to four hours. Solutions used have been procaine 1 percent, 0.5 percent and 0.25 percent, and pontocaine.

Advantages found are precision dosage, greater freedom for the anesthetist, decrease in the total amount of anesthetic administered and a resultant greater safety to the patient.

Volume II

The O.R. YEARBOOK Ready For Distribution

The enthusiastic reception of the first O.R. Yearbook from HOSPITAL TOPICS which contained the best of all that was in the O.R. Section during 1950, has led us to publish Volume II, which brings together the best features that appeared during 1951.

If you would like a copy of Volume II, a letter or postcard to the O.R. Editor, 30 West Washington Street, Chicago 2, Illinois, will bring you one without charge. Or, if you wish, you may write your request on the postage paid card in the Buyer's Guide Section opposite page 40.

Conserving Supplies in the Operating Room

By Sarah Collins, VA Hospital, McKinney, Texas

The concern over rising costs of equipment and labor that has been plaguing the hospital administrator is felt in the departments also. These suggestions for the conservation of supplies may be helpful in controlling waste in your department.

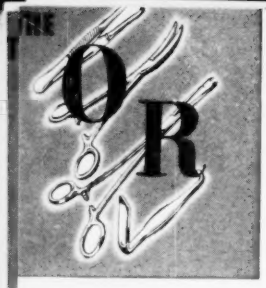
I. Supervisor outline own program first:
   1. Analyze situation in unit to determine minimum and maximum needs
   2. Set up a standard based on needs
   3. Have a minimum emergency supply available
   4. Appoint one person responsible for issuing supplies needed as used, perhaps on a list attached to door of supply closet
   5. Have a stated time for inventory
   6. Have regular meetings and conferences
   7. Plan so as to eliminate problems before they arise
   8. Conserve time by having personnel familiar with their work

II. In conferences and meetings:
   1. Make everyone conscious of program. The value of conservation must be clear in everyone's mind
   2. Designate responsibilities to different persons
   3. Stress the importance of *thinking* before *acting*
   4. Impress the old adage "haste makes waste"—always good
   5. Give demonstration or procedures on cleaning and care of equipment and supplies. Learn the operating mechanism of equipment
   6. List initial prices of equipment and materials as well as informing personnel on the cost of repairs
   7. State advantages from proper application, as for example,--battery box should be turned off before connecting light cords to carriers. This latter burns out the bulbs
   8. Give concrete examples of what to do
   9. Reclaim useable supplies, thus cutting down on budget and type of work

III. Some definite points to be emphasized:
   1. All lights off when not in use
   2. Steam off when no heat or sterilizing is actually required
   3. Use scratch pads instead of form paper for notes
   4. Keep fewer sterile supplies on hand thus eliminating out-dated re-sterilization
   5. Have water faucet connections in good repair
   6. Observe strict sterilization of goods to prevent wear of material and to cut down on time and steam
   7. Wrap supplies in a good estimate of actual use

IV. Keynote to success:
   1. Proper supervision
   2. Inventory
   3. Work planning
   4. Making everyone supply conscious by setting a good example
   5. Teamwork not only desirable but absolutely essential
   6. Think

The statements and conclusions in this program do not necessarily reflect the opinion or policy of the Veterans Administration.



Each month questions pertaining to O.R. problems and technics will be answered by Dr. Carl W. Walter, nationally known for his operating room technic courses and as the author of "Aseptic Treatment of Wounds" (Macmillan). Questions should be addressed care of the O.R. Editor, Hospital Topics.

Q. Possibly you are familiar with the "Singer Sewing Machine". It was being used quite often in clean cases over a period of a year and we had six infections.

The silk is wound on steel bobbins quite tightly in order for the machine to work smoothly. We believe that the silk must be wound too tightly to permit proper sterilization by steam.

Is there any method by which these bobbins can be sterilized by steam without too much trouble?

A. The Singer Stitcher should not be difficult to sterilize if properly cleaned. The silk should not be wound on the bobbins too tightly because it becomes weakened as it shrinks during sterilization. I suggest that you wind it on the bobbins and moisten it with several drops of water just before it is put in the sterilizer. Thirty minutes at 250° F. should sterilize it reliably. The Stitcher should be loosened at any joints before put in the sterilizer.

Q. Since I attended your Institute in Ann Arbor, I know you would be glad to tell me the correct method in preparing sterile cocaine solution for eye surgery. If using chlorobutanol, how long must the solution stand before considering it sterile? How much chlorobutanol should be used?

A. Cocaine solution can be made up exactly as the morphine solution described on page 300-301 of "Aseptic Treatment of Wounds." It can be stored indefinitely and when sterilized in saturated steam at 250° F. for 30 minutes, you need not add chlorobutanol.

Q. In the June 1951 issue Page 53 question and answers, I am referring to the need for suture ampoule jars and covers being heat sterilized. This seems to differ with the statement made in the "Aseptic Treatment of Wounds" Book on page 36 under Surgical Gut. I am confused and would like to know which method is correct.

A. In answer to your question regarding a pre-sterilized jar for sutures, if you use a jar with a tightly fitting lid or cover, you must sterilize the jar before filling with sutures or ampoules because the fumes of the formaldehyde disinfectant cannot penetrate between the two tightly opposed surfaces. If you use a jar with a loose cover, such as is described on page 36 of "Aseptic Treatment of Wounds", you may take a clean, unsterile jar and cover; fill the jar with ampoules or sutures; add the formaldehyde germicide and quarantine for 18 hours and then use. The fumes of the germicide will disinfect the rim of the jar and the inside surface of the cover.

Q. For the past month we have been having quite a bit of wound infections after surgery. For our skin preparation we use Ether, Alcohol 70% and Tr. Zephiran, however the alcohol we use is rubbing alcohol. I'm just wondering if this skin preparation that we use would have anything to do with these infections. We use Phisodeum for scrubbing hoods before surgery. We also boil our instruments before using (30 minutes). Our Surgeon does not like to use autoclaved instruments. We use Cotton for closure. It is also boiled for 30 minutes. I have done everything that I could to prevent these infections. I use diack controls, I've had my autoclaved checked. It's in perfect condition.

Now I'm wondering if it would be a good idea to have the Operating Room Cultured, to see if there is anything that may be the cause of these infections. I am also wondering if there is any suggestion you may be able to give me on the skin preparation, that may be better than what we are using. Personally I don't think the infection is coming from my department, but I do want to be sure and to do everything in my power to prevent these infections. I also boil my brushes after use and place them in a 1:1000 solution of mercury cyanide.

A. Boiling water sterilizers have no place in a modern operating room and should not be used where steam is available. I suggest you review Chapter 6 of "Aseptic Treatment of Wounds" for a description of the fallacies of boiling water sterilization.

Ether should not be used for skin preparations. It has no germicidal properties and is an explosion hazard. Whenever possible, the patient should be instructed to scrub his skin for 5 days before operation with any of the soaps or detergents containing hexachlorphene, G-11. At operation, the area is lathered with pHisoderm with G-11; the lather is shaved off with a sterile straight razor. The skin is then scrubbed with 1-1000 aqueous Zephiran alternated with 40% isopropyl alcohol. Six sets of scrubs are used. An alternate technic is to clean and shave the area as described above and then flood the area with 2% aqueous iodine. Let it stand for a minute and then remove the excess with 40% isopropyl alcohol.

I suggest you use a good Nylon bristle brush and sterilize it in saturated steam at 250° F. for 30 minutes after use. You need not soak them unless you particularly want to but if you do, mercury cyanide is hardly a germicide of choice. I would suggest you use an aqueous solution of any of the quaternary ammonium compounds—Zephiran, Phemerol, etc.

Q. Wish to confirm a matter in relation to the use of Aqueous Zephiran. Did I understand that Zephiran (Aqueous) may be used in the hand basin in which the Surgeons rinse their gloved hands off during the operation? I mentioned this to one of our Surgeons and he said he would think that Aqueous Zephiran might irritate some tissues.

A. Aqueous solutions of Zephiran are not toxic to tissues and 1-5000 aqueous Zephiran is a suitable solution to be used for rinsing gloves during an operation. Indeed,

several drops of Zephiran solution can be instilled in the conjunctival sac without causing symptoms or injection. You will find the toxicity studies made on Zephiran described in an article in Surgery, Gynecology and Obstetrics 67:683; 1938, "The use of a mixture of coconut oil derivatives as a bactericide in the operating room."

Q. Our E.N.T. specialists now use a telescoping lamp with a goose-neck and a head mirror. The switch is removed from the lamp and the plug is connected to an electric outlet with a locking device. This is 5½ feet from the floor. Even with these precautions, the District Engineer will not pass this light. We understand the A. S. Aloe Company carries a Prometheus Focalite—75 watt lamp. The telescoping tube stand and lamp are chrome plated and set in a heavy non-tipping base with a heavy goose-neck support lamp. Could you tell me whether the underwriters will pass this? If not, would you know of any piece of equipment now on the market which we could substitute?

A. The only portable equipment which should be bought for the operating room is that which bears the Underwriters' Laboratory seal of approval. Otherwise, you are likely to get into difficulty with the local inspection authorities. I regret that I am not familiar with the device you describe and cannot express an opinion.

Q. We have been separating our abdominal tape sponges from the rest of our laundry and have boiled them right in the operating room. We felt that the green dye from the linens would be absorbed in the sponges and make them unsafe for use. Can you tell us whether we could safely include them with the other laundry supplies or whether we should continue with our present practice?

A. I believe that you can launder your "abdominal tapes" with the remainder of the hospital laundry without danger to the patient.

Q. We now use a three-burner open-flame gas stove in our workroom for heating solutions and boiling special equipment in distilled water—i.e., syringes for eye irrigations. The suggested change was to have the gas stove removed and to purchase an electric heating cabinet to heat solutions. However this would create somewhat of a problem. We have only one small autoclave and two non-pressure boiling-water instrument sterilizers to sterilize all of the operating room supplies. Although these sterilizers are thoroughly cleaned once a week with Stero Klean solution, we still have too much sediment to safely use them for eye syringes, etc. Do you know of any type of small electric stove or burner which would comply with the National Fire Protective Association regulations?

A. It is not safe to have an open flame in an operating room for any purpose. I suggest that you sterilize your syringes for eye irrigations in a steam sterilizer. When suitably packaged, they can be done at odd times and need not interfere with your autoclaving schedule.

Q. Should visitors to the operating room be gowned when there is no observation amphitheatre?

A. They should change all their clothing and walk in their stocking feet which will ground them, keep street dirt out of the operating room and encourage them to go home early.

Q. Can saline solution be used in a transurethral prostatectomy?

A. Saline should not be used in a transurethral prostatectomy because it is a good electrolyte which interferes with the action of the cutting currents and liberates hydrogen and oxygen by electrolysis which in itself is a hazard. You can prevent hemolysis of blood during a transurethral by using a solution of glycol for irrigating.

Q. Why is acetic acid used on glassware?

A. It is used to remove alkali earth film from glassware but it is an expensive way of doing something which can be avoided by using a non-ionizing detergent for cleaning the glassware initially.

Q. How do you disinfect intubation tubes in a tuberculosis case?

A. They should be scrubbed inside and out with a solution of calcium hypochlorite (chlorinated lime) made with 4 teaspoonfuls of chlorinated lime to a gallon of water.

Q. Do you recommend using an operating room indiscriminately for clean and dirty cases?

A. Yes. There is no need for quarantining a room which had had a "dirty case." With a suitable technic for disposing of contaminated linen and instruments, that room can be used again just as soon as it is emptied.

Q. Does calcium hypochlorite have any effect on rubber?

A. Not if the articles to be disinfected are not left soaking. Drop the tubing, etc. in; flush through with the solution; rinse with tap water and dry.

Q. What germicide should be used for disinfecting dry instruments?

A. No germicide will act quickly enough to be practical.

Q. Is it necessary to cover instruments being carried from the sterilizer to an operating room?

A. No, not if the floors are kept clean; the nurse is wearing a mask and nobody talks over the instruments. The air itself will not contaminate the instruments.

Q. Are muslin boots satisfactory for use in the operating room?

A. No, muslin boots should not be worn in the operating room because they insulate the wearer from the floor. Shoes with conductive rubber soles should be standard footwear for the operating room personnel.

Q. Do you recommend disinfecting ampoules in 70% alcohol?

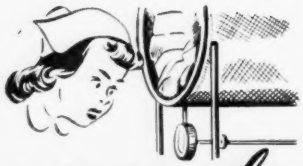
A. No. The alcohol does not destroy spores. The alcohol should be fortified for this purpose with formalin. A good formula is:

isopropyl alcohol 99%	700 cc.
formalin USP 37%	25 cc.
sodium nitrite	1.0 gm.
sodium bicarbonate	1.0 gm.
distilled water qs. ad.	1000.0 cc.

Q. Can ether be used for disinfecting the skin?

A. Ether should not be used for this purpose. It is wasteful and its vapor is an explosion hazard. The amount spilled during disinfection of the skin is enough to blow an operating room apart. It is not a good fat solvent; has no germicidal properties and is a poor detergent.

(Continued on next page)



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Q/R Mailbag

We have received a tremendous response for additional information and bookings for the films on aseptic technic offered by the Wilmot Castle Company. These have been forwarded to the Company. We have been informed that the interest in these films has been so great that they are booked for the next few months. All requests will be handled and we hope you will understand any delay in handling your inquiry.

The Editor
O.R. Section

QUESTION BOX continued

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Classified

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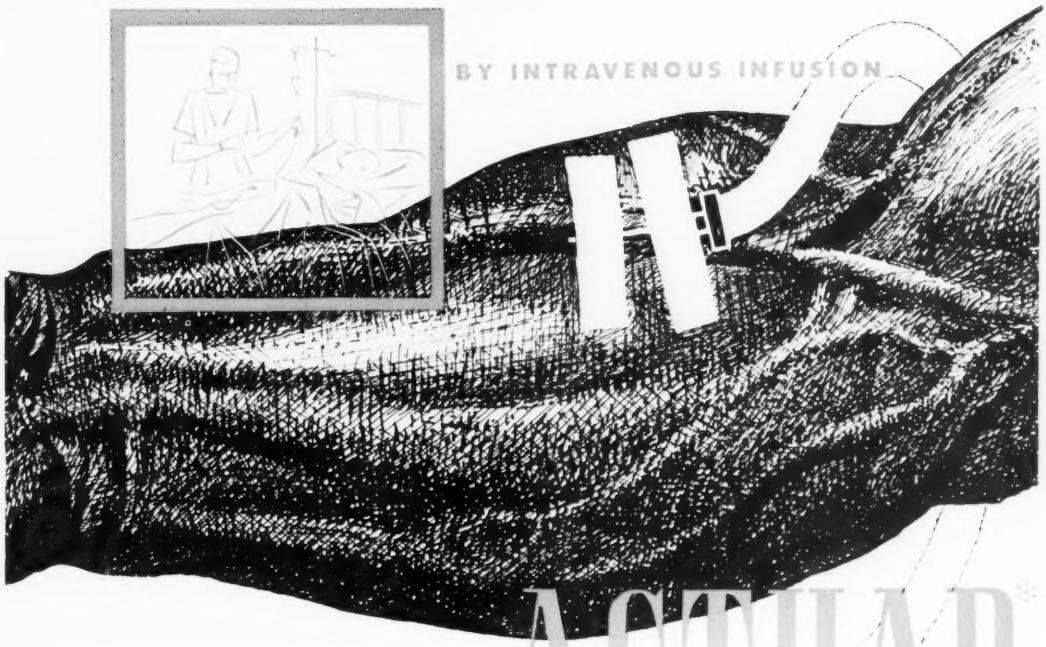
(Additional Classified on page 50)



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